

Employer Statement

Certification for Disability Benefits

Instructions: *Please complete this form and return to our office as soon as possible. This form must be on file in order to issue disability benefits to the employee.*

Employee Name: _____ SS No. _____

Employer Disability Premium Contribution _____ %
(If this information is incorrect, please indicate current employer disability contribution _____ %)

Does the employee make a premium contribution through a "pre-tax" program? Yes No

Employee Occupation: _____

Base Earnings \$ _____ Per year/month/week (Circle one)

Is this disability due to work related injury? Yes No

Has employment been terminated? Yes No

If yes, give reason and date of termination:

Please provide W-4 form on file

Date employee last worked: ___ / ___ / ___ Date returned to work: ___ / ___ / ___

Date employee expected to return to work: ___ / ___ / ___

Name and Address of Employer:

Signature: _____ Date: _____



SIGNIFICA BENEFIT SERVICES, INC.
P.O. Box 7777
Lancaster, PA 17604-7777
Telephone: 717-581-1300 * Fax: 717-581-8379
web site: www.significabenefits.com