AmTrust North America
An AmTrust Financial Company

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EMPLOYER STATEMENT

Claim #_____

Your employee or former employee has submitted a claim for New York State Disability Benefits. In order to properly process the claim, and in accordance with the New York State Disability Benefits Law, employers are required to provide a statement on behalf of any individual who has applied for benefits.

Your cooperation in completing and returning this form promptly will assist us in determining the employee's eligibility for Disability Benefits. Completed forms can be sent via email to dbclaims@amtrustgroup.com.

1. Employee's Name_____ SSN# _____
2. Address_____ City_____ State_____ ZIP_____
3. Date of Employment_____ Occupation? _____
4. Actual last date employee worked prior to disability _____
5. If employee has returned to work give date of return _____
6. If not yet returned to work, do you expect to rehire? ☐ YES ☐ NO
7. Date wages ceased _____
8. Are wages being continued during disability? ☐ YES ☐ NO
9. If yes, is reimbursement requested? ☐ YES ☐ NO
10. On what date did you receive the completed claim form? _____
11. Did disability occur as a result of employment? ☐ YES ☐ NO
12. Name of your Workers' Compensation Carrier _____
13. Employees' wages for last eight weeks **worked** prior to

WEEK NO.	(WEEK ENDING) MM / DD / YYYY	NUMBER OF DAYS WORKED	GROSS WAGES	WEEK NO.	(WEEK ENDING) MM / DD / YYYY	NUMBER OF DAYS WORKED	GROSS WAGES
1			$	5			$
2				6			
3				7			
4				8			

14. If employee received extras such as tips, board, meals, etc., state reported weekly value: $ _____
15. Employee's usual days worked: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN ☐ PART TIME ☐ FULL TIME
16. Has employee claimed disability benefits in the past 52 weeks? ☐ YES ☐ NO If yes, date _____
17. Is claimant an ☐ employee ☐ owner ☐ co-owner ☐ partner ☐ proprietor ☐ spouse of employer
18. Is employee presently a full-time high school student? ☐ YES ☐ NO
19. If employee is no longer in your employ, check reason for separation: Labor dispute ☐ Lack of work ☐ Fired ☐ Quit ☐
20. If employee was fired or quit, state reason._____ Date _____
21. Has the claimant received U.I. Benefits? ☐ YES ☐ NO If yes, give dates: _____
22. Is employee a member of a union which provides disability benefits? ☐ YES ☐ NO

    If yes, indicate name and address of union: _____
23. **IMPORTANT:** Indicate percentage employee contributes to premium _____%

IMPORTANT- COMPLETE THIS SECTION IN FULL

Employer _____
(Business Name)

Signature_____ Title _____

Disability Benefits
Policy No. WDL _____

Phone No. _____

Email _____

ADDITIONAL COMMENTS