

**Employer's Statement
Total Disability Benefits**

**American General Life Insurance Company
The United States Life Insurance Company in the City of New York**

Policy No(s). _____

Mail to: P.O. Box 81254, Cleveland, OH 44181 • Fax: 615-749-2932

TO BE COMPLETED BY EMPLOYER

1. Employee name _____
Hire date _____
Average number of scheduled hours per week _____

Date last worked ____/ ____/ ____
Dates employee unable to work (Full-time)
From ____/ ____/ ____ To ____/ ____/ ____
(MM/DD/YYYY) (MM/DD/YYYY)

2. Is Insured still in your employ? Yes No
Was the employee at work when the accident or sickness occurred? Yes No
Is a Worker's Compensation claim being filed? Yes No

Carrier: _____ Phone: _____

Date employment terminated ____/ ____/ ____
(MM/DD/YYYY)

3. Nature of Business: _____

4. Date returned to work:
Full-time ____/ ____/ ____ Part-time ____/ ____/ ____ / Hours per week _____
(MM/DD/YYYY) (MM/DD/YYYY)

If not returned, expected return to work
____/ ____/ ____
(MM/DD/YYYY)

5. Employee's job title: _____

6. Employee's duties include: _____

*** For clarification of duties, please submit a copy of the Insured's job description.**

7. Lifting	<input type="checkbox"/> Less than 15 lbs.	<input type="checkbox"/> 15 to 44 lbs.	<input type="checkbox"/> over 45 lbs.
Stooping/bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Crawling/kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Reaching/pulling/pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Repetitive motion	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Management Duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Driving	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent

8. Sitting (number of hours each day) _____ Standing (number of hours each day) _____

9. Walking (number of hours each day) _____ Climbing Stairs/Ladders (number of hours each day) _____

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Signature

Signed on (date) _____

Name (please print) _____

Title _____

Telephone Number _____

Fax Number _____

Email Address (please print) _____

If you are self employed, please submit evidence of self employment.