

PART C – Employer’s Statement

Employee’s name /Employee #		Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Lay-off <input type="checkbox"/> Leave of Absence
Hire Date:	Effective Date of Coverage:	Last date Employee Worked:
Weekly Salary:	Less than 10 years? <input type="checkbox"/> weekly disability of \$200.00	10 years or more? <input type="checkbox"/> weekly disability of \$400.00
Job description:	Were injuries or illness in any way connected with employee’s occupation? (Worker’s Comp filed)?	
Has employee returned to work?	Expected return to work date:	Disability ending date:
Job description:		
Signature of employer’s representative:		Date:

Comments: _____
