

**Group Marketing Services, Inc.**  
P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611  
**WEEKLY INDEMNITY BENEFITS**  
**EMPLOYER'S STATEMENT**

EMPLOYER'S NAME: \_\_\_\_\_

EMPLOYEE'S NAME: \_\_\_\_\_

POSITION: \_\_\_\_\_

FULL TIME HIRE DATE: \_\_\_\_\_

LAST DAY WORKED: \_\_\_\_\_

GROSS WEEKLY COMPENSATION: \$ \_\_\_\_\_

NET WEEKLY COMPENSATION: \$ \_\_\_\_\_

DOES COMPENSATION INCLUDE:

BONUS:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

PROFIT SHARING:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

OVERTIME:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

COMMISSIONS:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

OTHER:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

DESCRIPTION: \_\_\_\_\_

HAS EMPLOYEE COLLECTED ANY WAGES SINCE DISABILITY BEGAN (I.E. VACATION, SICK OR PERSONAL PAY):  YES OR  NO;

AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

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AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

PERCENTAGE OF **DISABILITY** PREMIUM EMPLOYEE CONTRIBUTES: \_\_\_\_\_

%; IS CONTRIBUTION DEDUCTED ON A PRE-TAXED BASIS:  YES OR  NO

EMPLOYEE'S DUTIES: \_\_\_\_\_

EMPLOYEE CAN PERFORM JOB DUTIES:  WITH **NO** RESTRICTION

WITH RESTRICTIONS

CANNOT PERFORM

EXPLAIN RESTRICTIONS: \_\_\_\_\_

WHAT JOB DUTIES CAN THIS EMPLOYEE NOT PERFORM DUE TO THEIR CONDITION? \_\_\_\_\_

DOES EMPLOYEE'S RESPONSIBILITIES INCLUDE HEAVY LIFTING OR HEAVY MANUAL LABOR?  YES OR  NO

IS THERE A POSITION AVAILABLE FOR THIS EMPLOYEE IF THEY CAN RETURN TO WORK UNDER RESTRICTED OR LIGHT DUTY?  YES OR  NO

IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT?  YES OR  NO

WAS A WORKER'S COMPENSATION CLAIM FILED FOR THIS DISABILITY:  YES OR  NO; IF YES, ATTACH WORKERS COMP CARRIERS DETERMINATION

TOTAL DISABILITY DATES: FROM: \_\_\_\_\_

TO: \_\_\_\_\_

HAS THIS EMPLOYEE BEEN OFFERED: FMLA EXTENSION:  YES OR  NO

COBRA EXTENSION:  YES OR  NO

HAS THIS EMPLOYEE ELECTED: FMLA EXTENSION:  YES OR  NO

COBRA EXTENSION:  YES OR  NO

The following is required in certain states: Any person who, knowingly and with intent to defraud or deceive any insurance company, files statement of claim containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.

NAME: \_\_\_\_\_  
(PRINT)

TITLE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_