

**Great Lakes
Employers
Association**



Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

**Employer Statement
Group Dismemberment Claim Form**

Please send completed form and all attachments to:

P.O. Box 19040
Kalamazoo, MI 49019-0040

**To avoid unnecessary delays, be sure all parts of the
Claim Form are completed according to the instructions.**

PART III - TO BE COMPLETED BY EMPLOYER

1. Full name of Insured - <i>(please print)</i> <small>Last, First M.I.</small>	2. Full time hire date	3. Work classification <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Commission Only
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4. Last day worked	6. Reason for not working after this date	7. Base salary \$ _____ per
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8. Work Schedule <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Contracted <input type="checkbox"/> Board Member	9. Hours worked per week
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7. If not actively at work immediately prior to injury, what was the reason?
 Disability Leave of Absence Resigned Discharged
 Vacation Temporary Layoff Retired Other: _____

8. Was insurance in force when injuries were sustained? Yes No; if "No" give date and reason for termination

8. Occupation	14. Did the accident happen at work? <input type="checkbox"/> No <input type="checkbox"/> Yes; <i>explain & attach copy of accident report</i>
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16. Employer name

17. Employer address – <i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
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18. Location name and address where employed <small>Location Name</small>	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>
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19. Do you have any additional information relating to this claim?

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

23. Signature

Employer contact name: _____ Date: _____

Signature: _____ Title: _____