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 - *(please print)* *Last, First M.I.*	2. Full time hire date	3. Work classification ☐Hourly ☐Salary ☐Commission Only

4. Last day worked	6. Reason for not working after this date	7. Base salary $ per

8. Work Schedule ☐Full Time ☐Part Time ☐Seasonal ☐Contracted ☐Board Member	9. Hours worked per week

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? ☐No ☐Yes; *explain & attach copy of accident report*

16. Employer name

17. Employer address – *Street* *City* *State* *Zip*

18. Location name and address where employed
Location Name *Street* *City* *State* *Zip*

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:_____