

# Group Marketing Services, Inc.

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

## WAIVER OF PREMIUM (LIFE) CLAIM FORM

### To Be Completed By Employer

1. EMPLOYEE'S NAME		2. SOCIAL SECURITY OR CERTIFICATE NUMBER	3. FULL TIME HIRE DATE
4. EMPLOYER'S NAME		5. OCCUPATION AT TIME OF DISABILITY	6. REASON FOR STOPPING WORK
7. RETURN TO WORK ON:	8. BASIC MONTHLY EARNINGS: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	9. WAS EMPLOYEE COVERED FOR LIFE BENEFITS ON LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. LAST DAY WORKED
11. EMPLOYEE'S DUTIES:			
12. EMPLOYEE CAN PERFORM JOB DUTIES: <input type="checkbox"/> WITH NO RESTRICTION <input type="checkbox"/> WITH RESTRICTIONS <input type="checkbox"/> CANNOT PERFORM EXPLAIN RESTRICTIONS:			
13. WHAT JOB DUTIES CAN THIS EMPLOYEE NOT PERFORM DUE TO THEIR CONDITION?			
14. DID EMPLOYEE CEASE WORK BECAUSE OF DISABILITY? <input type="checkbox"/> YES OR <input type="checkbox"/> NO			
15. DOES EMPLOYEE'S RESPONSIBILITIES INCLUDE HEAVY LIFTING OR HEAVY MANUAL LABOR? <input type="checkbox"/> YES OR <input type="checkbox"/> NO			
16. IS THERE A POSITION AVAILABLE FOR THIS EMPLOYEE IF THEY CAN RETURN TO WORK UNDER RESTRICTED OR LIGHT DUTY? <input type="checkbox"/> YES OR <input type="checkbox"/> NO			
17. IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT? <input type="checkbox"/> YES OR <input type="checkbox"/> NO			
18. WAS A WORKER'S COMPENSATION CLAIM FILED FOR THIS DISABILITY: <input type="checkbox"/> YES OR <input type="checkbox"/> NO; IF YES, ATTACH WORKERS COMP CARRIERS DETERMINATION			
19. TOTAL DISABILITY DATES: FROM: TO:			
20. HAS THIS EMPLOYEE BEEN OFFERED: FMLA EXTENSION: <input type="checkbox"/> YES OR <input type="checkbox"/> NO COBRA EXTENSION: <input type="checkbox"/> YES OR <input type="checkbox"/> NO			
21. HAS THIS EMPLOYEE ELECTED: FMLA EXTENSION: <input type="checkbox"/> YES OR <input type="checkbox"/> NO COBRA EXTENSION: <input type="checkbox"/> YES OR <input type="checkbox"/> NO			

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the Policy.

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 agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

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

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

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

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