

Employer's Statement (Disability)



Please PRINT clearly.

This form should be answered by the employer of the insured.

In connection with the employee's claim for: (Please check appropriate box) Total Disability Benefit on the life insured Premium Coverage Upon Death or During Total Disability of Initial Owner

1 Details Pertaining To Employee

If the space provided is insufficient, please use a separate sheet and attach to the form.

Employee (Last Name, First Name, M.I.)	Date Hired (Month/Day/Year)
Employee's occupation/position/title	Date Employee Last Worked (Month/Day/Year)
Immediately prior to disability, describe/list the routine functions/duties of employee's job/occupation:	
1.	
2.	
3.	
4.	
5.	

Employment status if employee is not actively at work. (Please check appropriate box(es) and indicate effective date(s))

Sick Leave w/ Pay; Effective Date _____

Sick Leave w/o Pay; Effective Date _____

Vacation Leave w/ Pay; Effective Date _____

Vacation Leave w/o Pay; Effective Date _____

Study Leave; Effective Date _____

Temporary Lay Off; Effective Date _____

Retired; Effective Date _____

Terminated; Effective Date _____

Resigned; Effective Date _____

Others (specify) _____

Prior to disability, check the following activities related to the employee's work or routine functions.

<input type="checkbox"/> Sitting	<input type="checkbox"/> Lifting Heavy Objects	<input type="checkbox"/> Attending To Customers (personal)
<input type="checkbox"/> Prolonged Standing	<input type="checkbox"/> Operate & Maintain Heavy Equipment/Machines	<input type="checkbox"/> Attend & Conduct Meetings/Seminars
<input type="checkbox"/> Frequent Walking	<input type="checkbox"/> Assembly Line Work (using hands/feet)	<input type="checkbox"/> Analysis, Judgement & Decision Making
<input type="checkbox"/> Frequent Climbing	<input type="checkbox"/> Furniture/Equipment Repair	<input type="checkbox"/> Supervision & Management
<input type="checkbox"/> Driving	<input type="checkbox"/> Routine Clerical Paper Work	<input type="checkbox"/> Sales & Marketing (client calls)
<input type="checkbox"/> Travel (land)	<input type="checkbox"/> Computer Work	<input type="checkbox"/> Others: please specify _____
<input type="checkbox"/> Travel (air)	<input type="checkbox"/> Cashiering	
<input type="checkbox"/> Travel (sea)	<input type="checkbox"/> Attending To Telephone Calls	

2 Employer's Signature

Signature of Authorized Signatory of Employer X	Printed Name
Position/Title of Authorized Signatory	
Place of Signing	Date of Signing (Month/Day/Year)
Business Address	Contact No.

