AMERICAN FIDELITY
a different opinion

American Fidelity Assurance Company | Mail to: Worksite Group Benefits Department
P.O. Box 25160 | Oklahoma City, Oklahoma | 73125-0160
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453
americanfidelity.com

Employer's Report of Claim

Name of Employer:	Phone Number:
Mailing Address: (P.O. Box or Street, City, State and Zip Code) (Please Print)	
Name of Employee:	Social Security Number: / /
Mailing Address: (P.O. Box or street, city and zip code)	
Date of Hire: / /	Occupation
Employment Status at time of Disability: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired	

DISABILITY

Date employee last worked: / /	Has employee returned to work? ☐ Yes ☐ No
If yes, date returned to work: / /	Full Time ☐ Part Time ☐

PREMIUMS

Does the employee participate in Social Security? ☐ Yes ☐ No	If no, hired after 4/1/86? ☐ Yes ☐ No
Does employer pay a portion of the disability premium? ☐ Yes ☐ No	If yes, what percent? %
Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? ☐ Yes ☐ No	
Have AFA disability premiums been withheld through the last date worked? ☐ Yes ☐ No	If not, what is the last date disability premiums were deducted? / /

SALARY AT TIME OF DISABILITY FOR EDUCATION EMPLOYERS

Number of Contract Days _____ for _____ school year. In-house days: First Day: _____

Annual Salary: $ Effective Date: / / Last Day: / /

SALARY AT TIME OF DISABILITY FOR ALL OTHER EMPLOYERS

Hourly: $ _____ Monthly: $ _____

Gross salary for previous calendar year: $ _____ Year-to-date, gross salary: $ _____

OTHER INCOME

Did Employee's disability result from employment? ☐ Yes ☐ No Has employee made a claim for Workers' Compensation? ☐ Yes ☐ No

If yes provide the name, address, and phone number of Workers' Compensation carrier: _____

Is employee entitled to Workers' Compensation for this disability? ☐ Yes ☐ No

Is the employee receiving or eligible to receive any of the following? ☐ Yes (Please complete the applicable boxes below.) ☐ No

Other Group Disability Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Salary Continuation Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Sick Leave Begins: _____ Ends: _____
Amount: _____ ☐ Daily ☐ Weekly ☐ Monthly

PTO/PPT Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Differential/Sabbatical Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Union Benefits Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

State Disability Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

For Union Benefits or Other Group Disability, please list provider's:
Name: _____
Phone: _____

EMPLOYER SIGNATURE

The above named employee may qualify for benefits under the American Fidelity group disability program. The information stated above is correct to the best of my knowledge and belief. Authorized signature of employer firm or authorized official: _____

Printed Name: _____ Date: _____

Email Address: _____ Phone: (____)_____ Fax: (____)_____

How do you prefer to be contacted? ☐ Email ☐ Phone ☐ Fax