standardsecurity
LIFE INSURANCE COMPANY
P.O. Box 25339
Farmington, NY 14425
phone 800-477-0087
claims@sslicny.com

New York State
REQUEST FOR EMPLOYMENT AND WAGE VERIFICATION

Part C - EMPLOYER'S STATEMENT

1. Employee's Name: _____ **2.** Soc. Sec. #: ☐☐☐ ☐☐ ☐☐☐☐

3. Employee's Address _____
Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: _____ **5.** Date of Hire: _____ **6.** Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Employee ☐ Owner ☐ High School Student **7a.** Date of Birth _____

8. Indicate the employee's normal work schedule: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer in your employ, explain why: ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (explain) _____

10. Date Employee last worked: _____ **10a.** Do you expect to rehire him/her? ☐ YES ☐ NO

11. Date Employee returned to work: _____

12. Are you paying wages or sick time: ☐ YES ☐ NO

a. If **YES,** time period paid: _____

b. Are you requesting reimbursement for this time period? ..... ☐ YES ☐ NO

13. Is Employee receiving or claiming Unemployment Ins? ..... ☐ YES ☐ NO

14. Is Employee receiving or claiming Workers' Comp. Ins? ..... ☐ YES ☐ NO

15. Did this Disability occur as a result of employment? ..... ☐ YES ☐ NO

16. Is Employee in a Union proving **MONETARY DISABILITY BENEFITS?** ..... ☐ YES ☐ NO

17. Are you aware of other employment claimant may have? ..... ☐ YES ☐ NO

18. Has the employee received DBL or PFL benefits within the past 52 weeks? ☐ YES ☐ NO

19. TAXABLE PERCENTAGE _____ % (If blank or not a %, we will tax at 100%)

POLICY NUMBER: _____

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability
(include value of Board, Lodging, and Tips if any)

	Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	

EMPLOYER INFORMATION:

Employer Name: _____ Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____ Title: _____ Date: _____

After COMPLETED, Do one of the following: SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: SSLICNY, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslicny.com