WAGE PROTECTOR® Program
Disability Initial Claim Form
Independent Contractor/Self Employed
Everest Reinsurance Company c/o Allied National-Claims Administrator
PO Box 29186
Shawnee Mission, KS, 66201-9186

PLEASE READ BEFORE COMPLETING THIS DOCUMENT

- SUBMISSION OF AN INCOMPLETE OR UNSIGNED CLAIM FORM MAY RESULT IN A DELAY IN PROCESSING CLAIM.
- Employer/Contractor's Statement is to be completed by the Insured's Employer(s)/Contractors(s).
- Employer/Contractor should return completed Employer/Contractor's Statement **to** Everest Reinsurance Company c/o Allied National-Claims Administrator, PO Box 29186, Shawnee Mission, KS, 66201-9186

Policy No._____ Insured's Name _____

EMPLOYER/CONTRACTOR'S STATEMENT

1. Start Date with your company_____/_____/_____
2. Last day worked _____/_____/_____ Date returned to work _____/_____/_____
3. Did individual work any period between these dates? Yes ☐ No ☐ If yes, please list dates _____
4. Occupation and specific duties _____
5. Full Time ☐ Part Time ☐ Is light duty available? Yes ☐ No ☐ Number of hours worked per week _____
6. Was the individual a: Contractor Yes ☐ No ☐
   Self-Employed Yes ☐ No ☐
   Seasonal Worker Yes ☐ No ☐
7. Is the present condition the result of an accident or injury on the job? Yes ☐ No ☐
8. If yes, please give a date of accident or injury. _____/_____/_____
9. If yes, please include a copy of the worker's compensation claim report filed, if applicable

Date	Signature (Employer/Contractor or Supervisor)	Company	Phone Number

Street Address	City or Town	State	Zip Code

If you have any questions, please call Everest Reinsurance Company c/o Allied National-Claims Administrator at 800-825-7531

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