Wage Protector® Program
SALARYGAP® 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 YOUR CLAIM.
- To file a claim for SALARYGAP, the current base income must be at least the Salary Gap Reduction Ratio shown in the Insured's Schedule Page less than the Insured's prior base income.
- SALARYGAP claims must be filed within 30 days after involuntary unemployment claim benefits cease.
- The Insured's Statement is to be completed by the insured.
- Attach a copy of last check stub(s) from prior contracting company(s) if not previously provided.
- Attach a copy of current pay stub(s) from current contracting company(s).
- Attach a copy of your Federal Tax Return for the past two years if not previously provided.
- Insured should return completed Insured Statement, signed Release of Information Authorization, and required pay stubs **to** Everest Reinsurance Company c/o Allied National-Claims Administrator, PO Box 29186, Shawnee Mission, KS, 66201-9186

Policy No. _____

INSURED'S STATEMENT
(To be completed by the insured)

1. Insured's Name _____
2. Address _____
3. City, State & Zip Code _____
4. Date of Birth _____/_____/_____ Home Phone _____
5. Are you ☐ Self-Employed or ☐ an Independent Contractor? If you are self-employed, please enter the information about your business. If you are an independent contractor, please enter the information about your contracting employer(s). If additional space is needed, please attach a separate sheet.
   a) Current Company Name _____
   b) Address _____
   c) City, State & Zip _____
   d) Phone_____ Current Occupation _____
   e) First Date Worked _____/_____/_____ Number of Hours Worked Per Week: _____
   f) Base income $_____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly
6. Are you receiving any other income such as:
   a) Unemployment Benefits ☐ Yes ☐ No Weekly unemployment income _____
   b) Other Income (explain) _____ Weekly income _____
7. Previous Contracts Lost by Company(s)/Employer (If you are an independent contractor and have more than one contracting employer, please attach a separate sheet with information for each contract.)
   a) Company Name_____ Phone_____
   b) Address _____
   c) City, State & Zip _____
   d) Prior Occupation _____ # of Hours Worked/Week: _____
   e) First Date Worked _____/_____/_____ Last Day Worked ____/____/_____
   f) Base salary $_____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

STATEMENT FROM THE INSURED

I DO HEREBY ACKNOWLEDGE THAT THE INFORMATION STATED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND

UNDERSTAND THAT ANY FALSE STATEMENTS MADE BY ME COULD BE REGARDED AS FRAUDULENT.

Signature of Insured _____ Date _____/_____/_____

For information or to check claim status, call 800-825-7531.

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RELEASE OF INFORMATION AUTHORIZATION

I ALSO AUTHORIZE MY CURRENT AND PREVIOUS CONTRACTING COMPANIES, UNION, STATE OR PRIVATE UNEMPLOYMENT OFFICE TO PROVIDE EVEREST REINSURNACE COMPANY C/O ALLIED NATIONAL-CLAIMS ADMINISTRATOR OR ITS AUTHORIZED REPRESENTATIVE, WITH ANY INFORMATION RELATIVE TO MY EMPLOYMENT HISTORY OR STATE UNEMPLOYMENT CLAIM IS IT RELATES TO THIS INSURANCE CLAIM.

Signature of Insured _____ **Date** _____/_____/_____

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- SUBMISSION OF AN INCOMPLETE OR UNSIGNED CLAIM FORM MAY RESULT IN A DELAY IN PROCESSING YOUR CLAIM.
- New contractor's statement(s) are to be completed by current contracting company(s) or union representative.

- **Employer(s) should return completed statement to:**
Everest Reinsurance Company c/o Allied National-Claims Administrator
PO Box 29186
Shawnee Mission, KS, 66201-9186

Policy No. _____

NEW CONTRACTOR'S STATEMENT (For Each New Contract)

1. Employee's Name _____
2. Start Date _____/_____/_____
3. Number of Hours Worked Per Week _____
4. Base Income $_____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly
5. Employee's Job Title _____
6. Type of Employment ☐ FULL-TIME ☐ PART-TIME ☐ SEASONAL
7. Brief Description of Duties _____

_____

_____

_____

_____ Date _____/_____/_____
Signature (Contracting Company Supervisor or Union Representative)

Company Name _____

Address _____

City, State, Zip _____

Phone No. _____