WAGE PROTECTOR® Program
Disability Initial Claim Form
EMPLOYEE - EMPLOYER
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's Statement is to be completed by the Insured's Employer.
- Employer should return completed Employer's Statement to Everest Reinsurance Company c/o Allied National - Claims Administrator, PO Box 29186, Shawnee Mission, KS 66021-9186

Policy No._____ **Insured's Name _____**

EMPLOYER'S STATEMENT

1. Start Date with your company_____/_____/_____
2. Last day worked _____/_____/_____ Date returned to work _____/_____/_____
3. Did employee 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 employee 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 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.