Wage Protector® Program
SALARYGAP® Initial Claim Form
EMPLOYEE
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 from employer.
- Attach a copy of current pay stub from current employer.
- Attach a copy of State Unemployment check stub, approval letter, or denial letter (if applicable).
- 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 _____ Home Phone _____
4. Date of Birth _____/_____/_____
5. Current Employer _____
   a) Address _____
   b) City, State & Zip _____
   c) Phone_____ Current Occupation _____
   d) First Date Worked _____/_____/_____ Number of Hours Worked Per Week: _____
   e) Base salary $_____ ☐ 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. Prior Employer _____
   a) Address _____
   b) City, State & Zip _____
   c) Phone_____ Prior Occupation _____
   d) First Date Worked _____/_____/_____ Last Day Worked ____/____/_____
   e) Number of Hours Worked Per Week: _____
   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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Shawnee Mission, KS 66021-9186

RELEASE OF INFORMATION AUTHORIZATION

I ALSO AUTHORIZE MY CURRENT AND PREVIOUS EMPLOYER, UNION, STATE OR PRIVATE UNEMPLOYMENT OFFICE TO PROVIDE EVEREST REINSURANCE COMPANY C/O ALLIED NATIONAL INSURANCE COMPANY 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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PLEASE READ BEFORE COMPLETING THIS DOCUMENT

- SUBMISSION OF AN INCOMPLETE OR UNSIGNED CLAIM FORM MAY RESULT IN A DELAY IN PROCESSING YOUR CLAIM.
- Employer statement is to be completed by current employer or union representative.
- Employer should return completed statement to Everest Reinsurance Company c/o Allied National - Claims Administrator, PO Box 29186, Shawnee Mission, KS 66021-9186

Policy No. _____ Employee's Name _____

NEW EMPLOYER STATEMENT

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

_____

_____

_____

_____ Date _____/_____/_____
Signature (Employer or Supervisor)

Company Name _____

Address _____

City, State, Zip _____

Phone No. _____

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