Wage Protector® Program
Involuntary Unemployment 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.
- Insured must remain involuntary unemployed for the 30-day waiting period prior to submitting a claim.
- Insured's Statement is to be completed by the Insured.
- Attach a copy of State Unemployment check stub, approval letter, or denial letter.
- Insured should return the completed Insured's Statement to Everest Reinsurance Company c/o Allied National-Claims Administrator PO Box 29186 Shawnee Mission, KS, 66201-9186
- Attach your last year Federal Income Tax return.
- Attach one of the following: Paystubs, Wage & Tax Statements (W-2, 1099's) or Proof of Income Letter.

Policy No. _____

INSURED'S STATEMENT

TO BE COMPLETED BY THE INSURED

1. Insured's Name _____
2. Address _____
3. City_____ State _____ Zip_____
4. Phone Number _____
5. Date of Birth _____/_____/_____
6. Employment: If you are an independent contractor and have more than one contracting employer, please attach a separate sheet with information for each contract.
   a. First Date Worked _____/_____/_____ Last Date Worked _____/_____/_____
   b. Number of Hours Worked Per Week _____
   c. Last Contracting Company's Name _____ Phone _____
   d. Contracting Company's address _____
      STREET ADDRESS CITY STATE ZIP
   e. Your Occupation _____ Specific Duties_____
   f. Employed from _____/_____/_____ through _____/_____/_____
   g. REASON FOR LEAVING (Check One):
      ☐ Layoff (other than seasonal) ☐ Lockout by Employer ☐ Seasonal Layoff (annual or routine) ☐ Released by Employer
      ☐ Left Voluntarily ☐ Retirement ☐ Sickness, Disability or Pregnancy ☐ Union on Strike
      ☐ Other (Explain): _____

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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I ALSO AUTHORIZE MY CURRENT AND PREVIOUS CONTRACTING COMPANY, 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** _____/_____/_____