

# Employer Statement

Disability Insurance Evidence of Insurability

## 1. Employer Information

Company Name

Employer ID / Group No.

Employer Address

City

State

Zip Code

Employer Contact Name

Phone Number

Email

## 2. Employee Information

Employee Name

Employee ID

Date of Hire

Employment Status

Class

Annual Salary

Salary Effective Date

Disability Coverage Applied For

Current Coverage Amount

## 3. Employer Statement

Please confirm that the above information is complete and accurate to the best of your knowledge.

Comments (optional)

## 4. Employer Authorization

Authorized Employer Signature

Print Name

Title

Date