Consent for Employer Verification

I hereby authorize my current and/or previous employer(s) to provide any information requested regarding my employment status, job duties, compensation, and any other information relevant to my application for Disability Insurance. I understand that this information will be used only for the purpose of processing my application.

Applicant Details

Full Name

Date of Birth

YYYY-MM-DD

Address

Employer Name

Consent & Signature

By signing below, I acknowledge that I have read and understood this consent form, and voluntarily agree to the release of my employment information to the Disability Insurance provider.

Applicant Signature

Date

Note: A photocopy or electronic copy of this authorization shall be considered as valid as the original.