MESSA
Good health. Good business. Great schools.

1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
517.332.2581 *or* 800.247.6951
Fax: 517.336.4042
www.messa.org

Employer Statement For
Short and Long Term Disability Income Benefits

THESE BENEFITS ARE PAID UNDER A POLICY UNDERWRITTEN BY LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is not to be completed until employee has stopped working.

In order to process your claim rapidly, please answer ***all*** questions.

Employee Information *(Please Print)*

Employee's Name	Contract Number

Do you, the EMPLOYER, contribute to the cost of the MESSA short-term/long-term disability program for this employee?

	Yes	No	
STD	☐	☐	If yes, give percent of **employer** contribution ____%
LTD	☐	☐	If yes, give percent of **employer** contribution ____%

If the EMPLOYEE contributes to the cost of a disability program with pre-tax dollars, please provide that percentage and check "pre-tax dollars." If not, please check "No."

	Yes	No	
Pre-tax dollars	☐	☐	If yes, give percent of **enrollee** contribution ____%
Pre-tax dollars	☐	☐	If yes, give percent of **enrollee** contribution ____%

Status of Employment

☐ **Absent - still on payroll.** Date employee is expected to return:	(m m / d d / y y)	☐ **Absent - medical leave has been granted.** Date medical leave will cease:	(m m / d d / y y)
☐ **Termination - Laid off** Date employee was laid off:		☐ **Termination - Retired** Date employee retired:	
☐ **Termination - Voluntary** Date employee terminated employment:		☐ **Termination - Involuntary** Date employee was terminated:	
☐ **Placed on leave (other than medical leave)** Date leave began:		***Note:*** *Please advise the MESSA Disability office in writing if the employment status for this employee changes after the submission of this information.*	

Is employee a 52-week employee? ☐ **Yes** ☐ **No** **Balanced calendar?** ☐ **No** ☐ **Yes** **If yes, send calendar.**

If *no*, please advise summer vacation dates: ***Last*** **day of current school year employee is required to work** (m m / d d / y y) **First day of next school year employee is required to report** (m m / d d / y y)

Last date employee was physically present on the job: (m m / d d / y y)

Has employee returned to work? ☐ **Yes** ☐ **No** **If *yes*, give date:** (m m / d d / y y) **If *no*, when do you expect employee to resume work?** (m m / d d / y y)

- Is there a possibility of workers' compensation liability in this claim? ☐ Yes ☐ No

If yes, please provide ***Incident Report*** and the ***Notice of Compensation or Dispute***.

Please notify the MESSA office ***IMMEDIATELY*** *when the employee returns to work.*

Occupational Classification and Level of Education

Date Employed (mm/dd/yy)	Total years of service in a Michigan public school: _____ Yrs.

Please check the classification that applies:

☐ Administrator ☐ Bus driver ☐ Clerical ☐ Other: _____

☐ Teacher	Subject Taught	Grade	***Note: It will be necessary to attach a copy of the employee's job description.***
Please indicate the current level of education:	☐ High School ☐ College	If college, give number of years: _____	

Please continue on the reverse ⟶

Contracted Annual Salary as of last day worked

Contracted Annual Salary *DO NOT prorate this amount*	Rate	Days Contracted	Hours
$_____	(If paid hourly) rate per hour: $_____	Contracted days for school year: _____	Number of hours worked per day: _____

Longevity and Sick Pay (Bank)

• Is employee entitled to longevity pay? ☐ Yes ☐ No	If **yes**, list the date of entitlement that is prior to the date employee was last at work: (m m / d d / y y)
If **yes**, list the dollar amount of the longevity entitled to prior to the date employee was last at work: $_____	Is this amount already included in the salary/hourly rate you are reporting? ☐ Yes ☐ No
• Please list the number of unused sick days at the time employee stopped work: _____	Date sick pay will begin: (m m / d d / y y)
Date sick pay will be paid through: (m m / d d / y y) Exhausted? ☐ Yes ☐ No	If you allowed employee to freeze sick time, through what date was sick time paid? (m m / d d / y y)

Information About Other Compensation

• To your knowledge, is the employee receiving any of the following?	**Amount**	**Date benefit will begin** (mm/dd/yy)	**Date benefit paid through** (mm/dd/yy)
Vacation Pay (weekly)			
Salary Continuance (weekly)			
Michigan Public School Employee Retirement			
Pension Plan/Early Retirement Incentive (monthly)			
Workers' Compensation or Occupational Disease (weekly)			
Social Security Disability or Social Security Retirement			

• Do you, the EMPLOYER, provide the employee with any other STD or LTD policy? ☐ Yes ☐ No

If **yes**, please provide the following information:	Name of Carrier	Policy Number
Contact Person	Phone Number ( )	

• What date will the employer's contractual obligation to provide MESSA health insurance end? (m m / d d / y y)

Please advise the MESSA Benefits office in writing when the 2018 maximum taxable wage base of $128,400 is reached if prior to the end of the sixth full calendar month following the month in which the employee last worked. Your timely completion of this form is greatly appreciated.

Signature of employer: _____ Date: _____

Title: _____ Phone number: ( ) _____ Ext.: _____

School district: _____ Fax number: ( ) _____

For further assistance or information, please contact MESSA Disability directly at:

Local: 517.332.2581 **Toll free: 800.247.6951** **Fax: 517.336.4042**

(You do not need to mail this form if you send it by fax.)

Please dispose of your previous supply of Employer Statements.

MESSA®

Good health. Good business. Great schools.

Rev. 1/2/18
Pr. 1/18 - 1PDF

MEA MEA-FS USO MESSA