

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
<p>Do you, the EMPLOYER, contribute to the cost of the MESSA short-term/long-term disability program for this employee?</p> <p>Yes No</p> <p>STD <input type="checkbox"/> <input type="checkbox"/> If yes, give percent of employer contribution ____%</p> <p>LTD <input type="checkbox"/> <input type="checkbox"/> If yes, give percent of employer contribution ____%</p>	<p style="color: blue;">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."</p> <p>Yes No</p> <p>Pre-tax dollars <input type="checkbox"/> <input type="checkbox"/> If yes, give percent of enrollee contribution ____%</p> <p>Pre-tax dollars <input type="checkbox"/> <input type="checkbox"/> If yes, give percent of enrollee contribution ____%</p>

Status of Employment

<input type="checkbox"/> Absent - still on payroll. Date employee is expected to return: (m m / d d / y y)	<input type="checkbox"/> Absent - medical leave has been granted. Date medical leave will cease: (m m / d d / y y)
<input type="checkbox"/> Termination - Laid off Date employee was laid off:	<input type="checkbox"/> Termination - Retired Date employee retired:
<input type="checkbox"/> Termination - Voluntary Date employee terminated employment:	<input type="checkbox"/> Termination - Involuntary Date employee was terminated:
<input type="checkbox"/> 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.
<p>➔ Is employee a 52-week employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Balanced calendar? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, send calendar.</p> <p>If no, please advise summer vacation dates: <i>Last day of current school year employee is required to work</i> (m m / d d / y y) ; <i>First day of next school year employee is required to report</i> (m m / d d / y y)</p>	
<p>➔ Last date employee was physically present on the job: (m m / d d / y y)</p>	
<p>➔ Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> 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)</p>	
<p>• Is there a possibility of workers' compensation liability in this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide <i>Incident Report</i> and the <i>Notice of Compensation or Dispute.</i></p>	
<p><i>Please notify the MESSA office IMMEDIATELY when the employee returns to work.</i></p>	

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:			
<input type="checkbox"/> Administrator <input type="checkbox"/> Bus driver <input type="checkbox"/> Clerical <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Teacher	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Subject Taught</td> <td style="border: none;">Grade</td> </tr> </table>	Subject Taught	Grade
Subject Taught	Grade		
Please indicate the current level of education:	<input type="checkbox"/> High School If college, give number of years: _____ <input type="checkbox"/> College		

Note: It will be necessary to attach a copy of the employee's job description.

Contracted Annual Salary as of last day worked

Contracted Annual Salary <i>DO NOT prorate this amount</i> \$ _____	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 2019 maximum taxable wage base of \$132,900 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.

