AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 25160 | Oklahoma City, OK 73125-0160
American Fidelity Assurance Company | 800-662-1113 | Fax: 800-818-3453 | **americanfidelity.com**

Employer's Report of Claim To be completed by the employer.

Save time and upload this form through your online account!

Name of Employer:	Phone Number: (with area code)
Mailing Address: (street, city, state, zip)	Fax Number: (with area code)
Name of Employee:	Social Security Number:
Mailing Address: (street, city, state, zip)	
Date of Hire: (MM/DD/YY)	Occupation:
Employment Status at time of Disability: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired	

Disability

Date employee last worked: (MM/DD/YY)	Has employee returned to work?: ☐ Yes ☐ No
If yes, date returned to work: (MM/DD/YY)	☐ Full-Time ☐ Part-Time

Premiums

Do you deduct Social Security from employee's pay? ☐ Yes ☐ No	
Are the disability premiums withheld before or after tax? Short-Term Plan: ☐ Before Tax ☐ After Tax Long-Term Plan: ☐ Before Tax ☐ After Tax	What percentage of the disability premium is paid by the employer? Short-Term % _____ $_____ Long-Term % _____ $_____
What was the last date disability premiums were deducted? (MM/DD/YY)	

Salary at Time of Disability for Education Employers

Number of Contract Days _____ for _____ school year.	In-house days: First Day: Last Day:
Annual Salary: $ Effective Date:	

Salary at Time of Disability for All Other Employers

Hourly: $	Monthly: $
Gross salary for previous calendar year: $	Year-to-date, gross salary: $

Other Income

Did employee's disability result from employment? ☐ Yes ☐ No			Has employee made a claim for Workers' Compensation? ☐ Yes ☐ No	
If yes provide the name, address, and phone number of Workers' Compensation carrier:				
Is the employee entitled to Workers' Compensation for this disability? ☐ Yes ☐ No				
Please indicate if the employee is receiving or eligible to receive any of the following:				
Sick Leave: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
Differential/Sabbatical: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
Salary Continuation/Other Paid Leave: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
State Disability: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
Paid Medical and Family Leave: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
Other Group Disability: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
Union Benefits: ☐ Yes ☐ No	Amount: $	Start Date:	End Date:	☐ Daily ☐ Weekly ☐ Monthly
For Union Benefits or Other Group Disability, please list provider's: Name:			Phone:	

Employer Signature

The above named employee may qualify for benefits under American Fidelity's disability income insurance plan. The information stated above is correct to the best of my knowledge and belief. Authorized signature of employer firm or authorized official: _____

Printed Name: _____ Title: _____ Date: _____

Email Address: _____ Phone: (with area code) _____ Fax: (with area code) _____

How do you prefer to be contacted? ☐ Email ☐ Phone ☐ Fax