Please allow 5 business days for your request to be processed, not including holidays or weekends.

Contact person:
Last Names A- K – Jessika Sutton
Last Names L- Z – TaJuana Simons

Standard Employment Verification Request Form

<u>*This Employment Verification Request Form is to be used ONLY for Disability, Loss of Wages or employees who resigned/terminated prior to 2006.</u>

Name_____ Today's Date_____

Full Social Security Number_____ Job Title_____

Telephone Number _____ Signature _____

What information are you requesting? Please check all that apply:

<u>Important Information for All Disability Claim Forms & Loss Wage Requests:</u>

If you have missed 10 or more consecutive days of work while under the care of a physician you MUST file a Leave of Absence with the Department of Benefits & Insurance (Room 120) before your form can be processed.

If you have missed 9 days or less you MUST supply a statement from your physician listing the days you were under his/her care before your form can be processed.

____ Disability Claim Form
Are you currently on or have you filed for a Leave of Absence (LOA)? Yes ___ No___.

____ Loss Wage *Due to an accident or injury. Please see note above for guidelines on processing your request.

____ Verification of Employment *Employees/Ex-employees who terminated or resigned prior to 2006 only.

<u>Please check method of release for the information you have requested:</u>

____ Mail to Home Address:

_____
(Street Address) (City, State) (Zip)

____ Pick Up ((You will be contacted at the number you listed above once your request has been processed.)

____ Fax *Fax Number _____ Attention: _____