

## DEPARTMENT STATEMENT

Employee Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

The above named employee has submitted a claim to Liberty Mutual for Short-Term Disability. Disability benefits will start after the employee is done using sick leave and/or vacation, or has reached the end of their waiting period, whichever is later. We must provide the insurance company with the following information:

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1. Last Day The Employee Worked: \_\_\_\_\_
2. Number Hours Worked On Last Day: \_\_\_\_\_
3. Sick Leave Paid (From/To) \_\_\_\_\_
4. Vacation Paid (From/To) \_\_\_\_\_
5. Days on Comp. Time (From/To) \_\_\_\_\_
6. Holiday Pay \_\_\_\_\_
7. Date Leave **Without** Pay Begins: \_\_\_\_\_

8. Is there the possibility for Worker's Compensation with this claim? Extended Sick Leave 80% Benefit received with Work Comp.  YES  NO

From \_\_\_\_\_ to \_\_\_\_\_

9. Is the employee normally scheduled to work a full 12 months each year.  YES  NO

If on furlough, give periods of employment: from \_\_\_\_\_ to \_\_\_\_\_

10. Before this disability, was the employee working  Full  Part  
• Part Time give percentage \_\_\_\_\_% Time Time

11. Indicate the employee's Normal weekly schedule:

(e.g., Mon.-Sun., 8 hrs/day)

Hours Worked MON TUES WED THURS FRI SAT SUN

12. If part time, was the reduction in work hours due to this disability?

Indicate modified schedule: (e.g., Mon.-Sun., 8 hrs/day)

Hours Worked MON TUES WED THURS FRI SAT SUN

13. *ATTACH COPY OF CURRENT TIME CARD AND FAMILY MEDICAL LEAVE LETTER, IF ELIGIBLE.*

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Completed by: \_\_\_\_\_ Title: \_\_\_\_\_

Department: \_\_\_\_\_ Extension: \_\_\_\_\_ Date: \_\_\_\_\_

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