

How to Complete an Employer's Statement

Per the WHAT INFORMATION DO WE REQUIRE OF YOU? provisions of your group long-term disability income insurance and short-term disability income insurance policies, Symetra may require information about your employees, occupational information and any other information reasonably required to process claims under those policies. Timely and accurate completion of the Employer's Statement is essential for ensuring a smooth claim process and positive experience for your employee. The following instructions will guide you through the different fields on the form and how to complete them correctly.

Fields 1-10

Symetra Life Insurance Company | Claims Department

Mailing Address: PO Box 1230, Enfield, CT 06083 | Toll Free Number 1-877-377-6773 | Fax Number 1-877-737-3650

Employer's Statement

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1 Employee Name	2 Phone No.
Street/Box/Apt.	3 Social Security No.
City, State, Zip	4 Date of Birth
5 Date of Hire	6 Regularly Scheduled Hours Per Week
7 Employee's STD Insurance Effective Date	
8 Employee's LTD Insurance Effective Date	9 Occupation (A job description is required.)
10 Does employee contribute toward the STD premium? (Include payroll stub with premium deductions) ☐ No ☐ Yes If yes, ☐ Pre-Tax ☐ Post-Tax If Post Tax, _____ % paid by employer _____ % paid by employee	

Special Notes:

(7) Employee's STD Insurance Effective Date

This date should be the date the employee's current level of coverage originally went into effect. It should not be based on the carrier's effective date unless the employee changed their coverage as part of the transition in disability carrier.

Example 1:

Eddie is a new hire as of 6/2/21 and enrolls in the employer paid STD plan. The eligibility waiting period for the coverage is the first of the month following 90 days of employment. His STD insurance effective date would be 9/1/21.

Example 2:

Jane enrolled in employer paid core STD coverage as a new hire in. Effective 1/1/2020, she enrolled in the buy-up coverage. As of 1/1/21, Symetra took over the disability program from the prior carrier she enrolled in the buy-up under. Her STD insurance effective date is 1/1/2020 (the original date of enrollment in her current level of coverage, regardless of the carrier change).

(8) Employee's LTD Insurance Effective Date

This date should be the date the employee's current level of coverage originally went into effect. It should not be based on the carrier's effective date unless the employee changed their coverage as part of the transition in disability carrier (see STD examples above).

(10) Premium Contributions

Premium contributions and whether they are on a pre-tax or post-tax basis is important because it determines whether the disability benefit payable to the employee is taxable. For most STD plans, we know the taxability based on the policy, but it's especially important to complete this section for variable contribution plans, where the percentage of premium paid by the ER and by the EE is not consistent across all employees.

Fields 11-21

11 Policy No.		12 Policy Division No.		13 Policy Class	
14 Employee's Work Schedule		☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Union ☐ Non-Union			
15 Check Regular Workdays		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat			
16 If not at work when disability began, check status and provide date ☐ Terminated ☐ Leave of Absence ☐ Other: _____ ☐ Laid Off ☐ Sick Leave ☐ Vacation ☐ Resigned Date _____		17 How was employee paid? (check frequency and types) Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly Type(s): ☐ Hourly ☐ Bonus ☐ Salary ☐ Commission			
18 Salary Prior to Date Last Worked Base Weekly Wages \$ _____ W-2 Earnings \$ _____ Overtime \$ _____ Commissions \$ _____ Bonus \$ _____		19 Date Last Salary Increase _____ 20 Employee Work Schedule at Time Last Worked _____ Days per week _____ Hours per week 21 Prior off-work period for the same condition: from _____ through _____			

Special Notes:

(17) Employee Pay – please select the frequency of the employee's regular pay and then what type(s) of pay are applicable to the employee.

(18) Earnings – please note that this field is asking for information as specifically relates to the employee's earnings as of the employee's last day worked. Regardless of what frequency was selected in the previous field (17), please provide base weekly wages, along with any other applicable compensation that is included in the disability policy's earnings definition, such as a commissions or bonuses, for the employee. If this field is not completed correctly, it may result in either an overpayment or underpayment of benefits to the employee.

Fields 22-30

22 Coverage under a prior STD policy? ☐ No ☐ Yes If yes, provide the inclusive dates of coverage: From _____ Through _____ Was employee insured under your prior LTD policy? ☐ No ☐ Yes If yes, provide the inclusive dates of coverage: From _____ Through _____ Life Waiver of Premium coverage? ☐ No ☐ Yes If yes, effective date of coverage and Class _____			
23 New York DBL? ☐ Yes ☐ No New Jersey TDB? ☐ Yes ☐ No (If yes, complete reverse side)	24 Date Last Worked _____	25 Hours Worked That Day _____	26 First Day Out _____
27 Has Employee Returned to work? ☐ No ☐ Yes If yes, Date _____ ☐ Full Time ☐ Part Time	28 Date Paid Through _____ For _____ ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Pay		
29 Note: If premium is taken prior to tax withholding the benefit will be considered pretax. If premium is taken after tax withholding the benefit will be considered posttax. Please indicate if this is gross-up.			
30 Does employee contribute toward the LTD premium? (Include payroll stub with premium deductions) ☐ No ☐ Yes If yes, ☐ Pre-Tax ☐ Post-Tax If Post Tax, _____ % paid by employer _____ % paid by employee			

Special Notes:

(22) Prior Coverage

It's important for Symetra to understand if the employee had coverage under the prior carrier as it allows us to determine whether an employee may be subject to a pre-existing condition investigation, particularly for voluntary disability plans. If the employee had coverage under a prior STD policy, we also require you to provide proof of enrollment (such as a screenshot from your ben admin system) when you return the completed Employer's Statement.

(30) Premium Contributions

The premium contributions field provides Symetra with information as to whether premiums are paid on a pre-tax basis, post-tax basis or a variation of both. This is important because it determines whether the disability benefit payable to the employee is taxable and the percentage of the benefit that may be taxable. For most LTD plans, we know the taxability based on the policy, but it's especially important to complete this section for variable contribution plans, where the percentage of premium paid by the employer and by the employee is not consistent across all employees.

Field 31

31	Employee is Eligible for:	No	Yes	If yes, Weekly or Monthly Amount	Wk	Mo	Provider Name/Address	Date Benefits Begin	Through
	Salary Continuation	☐	☐	\$	☐	☐			
	Disability Pension	☐	☐	\$	☐	☐			
	Retirement Pension	☐	☐	\$	☐	☐			
	State Disability	☐	☐	\$	☐	☐			
	Unemployment	☐	☐	\$	☐	☐			
	Social Security	☐	☐	\$	☐	☐			
	Workers' Compensation	☐	☐	\$	☐	☐			
	Has Workers' Comp. claim been filed?	☐	☐	If Workers' Compensation has been denied, submit copy of denial with this claim.					

Reminder: Life premiums must be paid throughout the Life Waiver of Premium elimination period to apply for this benefit, even if the claimant has to convert to an individual policy to maintain coverage. Please refer to the Life policy.

Special Notes:

This table is necessary for us to determine whether the employee may be receiving Other Income that would be an offset to the employee's disability benefit. If the employee has filed for Worker's Compensation, please make sure to note this in the final line of the table and provide a copy of the WC denial letter if applicable, as WC is generally exclusion to STD benefits, and an offset to LTD benefits.

Fields 32-34

Section 3: Continued

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

32 Does your company have a rehire or return to work policy for disabled employees? ☐ No ☐ Yes

What is the name of the person we should contact if we identify a return to work option?

33 Employee's medical insurance carrier or HMO (provide policy or ID No.)

Name

Address

34 Only complete this information if the employee is eligible to receive New York (DBL), or New Jersey (TDB).

Employee Name	Social Security No.	Weekly Wages Last Day Worked
		\$

In the following spaces show dates and claimant's GROSS earnings in New York and/or New Jersey employment during the last weeks prior to the week disability began.

	Calendar Week End Date	Gross Wages
Calendar Week in Which Disability Began		\$
Prior Week Before Disability		\$
2nd Week Before Disability		\$
3rd Week Before Disability		\$
4th Week Before Disability		\$
5th Week Before Disability		\$
6th Week Before Disability		\$
7th Week Before Disability		\$
8th Week Before Disability		\$
Total		\$

Special Notes:

(32) Return to Work Policy and (33) Medical Insurance Carrier – return to work policy and requirements are generally addressed during implementation, however, the contact to discuss return to work options with may change. Filling out this field provides Symetra with a current contact that our vocational department can coordinate with to assist in your employee's return to work plan. We only use medical insurance carrier on an exception basis, so this field is optional.

(34) NY DBL and NJ TDB – this field is only required for employees who have earnings in NY and/or NJ as the earnings definition for those benefits differ than STD.

Once you have completed the Employer's Statement, please use your secure email, and send this completed form, along with any other supporting documentation (such as proof of enrollment and/or WC denial letter) to LADCLA@symetra.com or fax it to (877) 737-3650.