SHORT TERM DISABILITY CLAIM FORM EMPLOYER'S STATEMENT

Reset Form

1. Name of employer

Name of employee (first, middle, last)

Name of supervisor	Phone number	Email address

2. Has coverage for the employee been terminated? ◯ yes ◯ no — if yes, provide date and reason(s):

Date employee last worked (dd/mmm/yy)	Time ◯ am ◯ pm	Was this a full shift? ◯ yes ◯ no Note additional details in section 3.
Date employee returned to work (dd/mmm/yy)	Time ◯ am ◯ pm	Was this a full shift? ◯ yes ◯ no Note additional details in section 3.

Has modified work been offered to the employee? ◯ yes ◯ no (please provide details below)

Employee's job title

State exact duties and/or provide physical demands analysis/job description of the employee:

3. **Additional Information** - please provide any other information you think might help us in the consideration of this claim.

4. **Declaration**

I certify that the above information is true and complete.

Signature of Authorized Company Official X	**Date** (dd/mmm/yyyy)

Name and title of Authorized Company Official

Phone number	Fax number	Email address

Please send this completed form to:

Email: sherwinwilliamsclaims@empire.ca

Fax: 1 855 430-9455

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