RESET FORM

PART B - EMPLOYER'S STATEMENT

_____ % PREMIUM PAID BY EMPLOYER

IMPORTANT: *To enable your disabled employee to receive TDI benefits within 10 days as required by law, it is imperative that you complete the following information for prompt submittal to your insurance carrier.*

1. Claimant's Name	2. Claimant's Occupation	3. Employer Dept. of Labor No.

4. TDI Group & Account Number	5. Firm or Trade Name	6. Business Address

7. In reporting wage information below, use gross wages, which include wages and all other remuneration such as commissions, bonuses, tips and cash value of meals, lodging, etc. Answer either A, B, or C.

A. If claimant was paid on a salary basis, enter claimant's weekly or monthly salary earned in the last week or month prior to the date claimant's disability began:

Week $ _____ Month $ _____

B. If paid on an hourly basis, give rate per hour $ _____. Enter the weekly earnings for the past 8 weeks prior to the date disability began, including the last date worked. (Include reported tips)

Week No.	Week Ending			No. Days Worked	Gross Amount
	Month	Day	Year		
1					
2					
3					
4					
5					
6					
7					
8					
Total	XXXX	XXXX	XXXX		

C. If claimant received any or all earnings on a commission or piecework basis, enter these earnings for the last 52 weeks prior to the date claimant's disability began:

This covers the period:

From: _____ through _____
(month/day/year) (month/day/year)

Earnings: $ _____

8. Worked: ❑ Full-time ❑ Part-time

Date hired: _____
(Month) (Day) (Year)

Date last worked prior to disability:

_____
(Month) (Day) (Year)

If returned to work, give date: _____

9. Check days normally worked:

❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat

If on rotation, give number of days worked per week: _____

10. Enter the following for the last 52 weeks prior to the date the employee's disability began:

Calendar Quarter Ending	No. of Weeks Worked	No. of Hours Worked Per Wk.	Total Wages Earned

11. Do you think this disability was caused by the claimant's job?

❑ Yes ❑ No ❑ Unknown

Was an Employer's Report of Industrial Injury WC-1 filed?

❑ Yes ❑ No

If yes, advise name and address of Worker's Compensation carrier:

_____

_____

_____

_____

12. Has or will this employee receive all or any portion of the period of disability covered by this claim:

Wage	❑ Yes	❑ No
Salary	❑ Yes	❑ No
Sick leave pay	❑ Yes	❑ No
Vacation pay	❑ Yes	❑ No
Separation pay	❑ Yes	❑ No

If yes, show period: From: _____ through _____ Amount $ _____
(month/day/year) (month/day/year)

13. Mail the doctor's statement to:

I hereby certify that the above information is true and complete to the best of my knowledge.

Print name of employer or employer's representative	Signature of employer or employer's representative	Date

Title	Email Address	Tel No.
		Fax No.