# Employer's Report of a Disability Claim

**Use this form to report STD and LTD claims.**

**To be completed by the Employer (Incomplete forms will be returned)**

Employer Name

**Mail or Fax to:**
**TRISTAR Benefit Administrators**
PO Box 32363, Long Beach, CA 90832
Tele: 877/874-3518
Fax: 562/495-6687

| Employee's Last Name | First Name | Middle Initial | Social Security Number -- -- |
|---|---|---|---|
| Address | | | Phone Number |
| City/State/Zip | | | |
| Date of Birth | Date of Hire | Date Last Worked | ☐ Female ☐ Male |
| Employee's basic earnings $ ☐ Hourly ☐ Weekly ☐ Semi-monthly ☐ Monthly ☐ Annually | | | Marital status # Exemptions<br>YTD FICA Taxable Wages |
| Employee's Division and Location | | | |

Employee Stopped Working Because

- ☐ Employee reported off-the-job illness or injury
- ☐ Employee reported on-the-job illness or injury
- ☐ Personal Leave of Absence began on _____.
- ☐ Terminated as of _____.
- ☐ End of Season
- ☐ Other:
- ☐ Temporary layoff without pay as of _____ with definite Return to Work date of _____.
- ☐ Permanent layoff without pay as of _____ with no definite Return to Work date.

| Has employee Returned to Work? ☐ Yes ☐ No | Date returned to work | ☐ Full time ☐ Part time ☐ Regular duty ☐ Modified duty |
|---|---|---|
| Occupation/Job Title (Please attach copy of job description) | | Nature of occupation ☐ Light labor ☐ Heavy Labor ☐ Clerical/administrative |
| Work schedule at time last worked<br>Days per week: Hours per day:<br>Hours per quarter: | | Employee's classification ☐ Class 1 Full time ☐ Class 2 Part time ☐ Class 3 Other |
| Will or has the employee filed for disability benefits provided by any employer/employee, labor management, state disability, or union welfare plan? ☐ Yes ☐ No | | If "Yes" weekly/monthly amount $<br>Date payments began: |
| Physician Name | Physician Phone | Physician Fax |
| Name of workers' compensation carrier (if work related) | | Address/phone |

| Print or Type Name/Title of Employer Representative | Telephone | Fax |
|---|---|---|
| Signature | | Date |