

NATIONAL SECURITY INSURANCE COMPANY
Elba, Alabama 36323

EMPLOYER'S STATEMENT

TOTAL DISABILITY BENEFITS

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc. It must not be completed by a Clerk, Bookkeeper, or Forman, unless specially authorized, nor by any Agent of NATIONAL SECURITY INSURANCE COMPANY.

1. Full name of Insured.

2. Name and business address of Insured's employer.

3. Nature of Business.

4. What was exact nature of work performed by Insured prior to his present condition?

5. When did Insured enter your employ?

6. (A) When was Insured compelled to give up his duties? (Give exact date)

(Month) (Day) (Year)

(B) When was Insured compelled to give up all his duties?

(Month) (Day) (Year)

7. Is Insured's illness or injury the sole cause of his absence from duty? If not, give particulars.

8. Has Insured been absent from work before because of any illness or injury? If so, give particulars.

9. (A) Is Insured still in your employ?

(B) If so, when do you expect him to return to work?

Signature

Position

Dated

Witness

Dated