LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349 GADSDEN AL 35902

EMPLOYER'S CERTIFICATE

To be completed by the employer, timekeeper, or superior officer under whom employee was working when disabled.

Policy Number(s): _____ Claim Number: _____

Name of Employee : _____

Date of Birth: _____ SSN: _____

On what date did the accident occur? _____-_____-_____ Time:____:____ ☐AM ☐PM

On what date did the sickness commence? _____-_____-_____ Time:____:____ ☐AM ☐PM

Did the accident happen while working on-the-job? ☐YES ☐NO

What was the last day the employee worked? _____-_____-_____ Time:____:____ ☐AM ☐PM

If injured, how did the accident happen? _____

_____

What was the employee's occupation? _____

What were the employee's usual duties? _____

What were the employee's monthly wages? _____

On what date did the employee first resume work? _____-_____-_____ Time:____:____ ☐AM ☐PM

If partially disabled, what duties was the employee unable to perform? _____

_____

On what date did the employee resume full duty? _____-_____-_____ Time:____:____ ☐AM ☐PM

Remarks: _____

_____

_____

_____

_____ _____

Name (Please Print) Title

_____ _____

Signature Name of Company

_____

Address:

_____-_____-_____ _____-_____-_____

Phone Number Date