MUTUAL

CLAIMANT'S STATEMENT
IN CASE OF LOSS OF EMPLOYMENT

Policy Number: _____

Name of Insured: _____

	YES	NO
1- Do you think that you will be on unemployment for more than 30 days?	❑	❑
2- Was you employment:		
a) seasonal?	❑	❑
b) part time?	❑	❑
3- Are you related to your former employer?	❑	❑
4- (For female) **Did you leave your employment due to pregnancy, delivery or abortion?**	❑	❑
5- Is the loss of employment due to:		
a) an illness or injury?	❑	❑
b) alcoholism, drug or prescription drug abuse?	❑	❑

FOR ANY CLAIM, PLEASE ATTACH TO THIS FORM YOUR LAST EMPLOYMENT STATEMENT.

Completed at _____ this _____day of _____ 20_____

X _____
CLAIMANT'S SIGNATURE