EMPLOYER'S REPORT OF CLAIM

State Form 45548 (R3 / 12-03)

STATE OF INDIANA
State Personnel Department,
Benefits Division Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (317) 803-7200 or (317) 574-7876
Fax: 317-574-7865

* The request for your Social Security number is MANDATORY according to IC 4-1-8 and this record cannot be processed without it.

This Information is to be completed by the agency.

Name of employee		Social Security number *
Type of claim: ☐ Short Term Disability ☐ Tort ☐ Workers' Compensation Minimum Benefits		
Salary (bi-weekly)	Payroll A orB	Latest hire date *(month, day,* year)
Date employee was last present at work	Check one: ☐ Full Time ☐ Part Time	

Leave Balances as of 31st day off work:

_____ VACATION

_____ PERSONAL

_____ SICK

_____ COMPENSATORY

_____ SPECIAL SICK LEAVE (if applicable)

Date employee went or will go out of Pay Status	Did claim result from job activity? ☐ Yes ☐ No	Has Employers Report of Injury / Illness of Employee (State Form 34401) been filed? ☐ Yes ☐ No

If the employee chooses option #3, please notify the Disability Program before all leave has been exhausted.

Please add any additional comments:

Name of agency	Telephone number
Agency address (number *and street,* city, state, ZIP code)	
Name of person completing form (please print)	Title
Signature of Authorized Representative	Date signed *(month, day,* year)