CITY OF SAN JOSE
LONG TERM DISABILITY CLAIM
TIMEKEEPER'S STATEMENT

DEPARTMENT TIMEKEEPERS: Please complete this form as soon as possible and send it along with the Employer's Statement to: Employee Services / Benefits, 2nd Floor, Wing. FAX # (408) 999-0862. **Do not complete the Employer's Statement. Only Section 1 of the Employer's Statement is to be completed by the employee**. If you have any questions, contact Human Resources / Benefits at (408) 535-1285.

Employee's Name:	Work Phone # (408) _ _ _ - _ _ _ _
Employee's SSN: _ _ _ - _ _ - _ _ _ _ ID# _ _ _ _ _ _	Employee's Dept.
Timekeeper's Name:	Work Phone # (408) _ _ _ - _ _ _ _
Supervisor's Name:	Work Phone # (408) _ _ _ - _ _ _ _

Is this a work related injury? **Yes:**☐ **No:**☐
Has the employee filed for workers compensation? **Yes:**☐ **No:**☐

Employee's status on the date of disability: Actively working? **Yes:**☐ **No:**☐
If no, please note status below: Was employee on (leave of absence, disability, vacation, other?)

_____

Number of hours worked per week: _____

Last day of work: _____ Number of hours worked on last day: _____

Date employee returned to work following leave: _____
If returned, did employee return to full duty? **Yes:**☐ **No:**☐

List separately all time taken (i.e. sick, vacation, comp, leave without pay, other).
Note: Sick leave taken after the 30-day benefit-waiting period is considered deductible income and will reduce the amount of long-term disability payments.

DATE (S) FROM	DATE (S) TO	TYPE OF LEAVE TAKEN

Is employment now terminated? **Yes:**☐ **No:**☐ Is employee scheduled for termination? **Yes:**☐ **No:**☐
If yes, date: _____ If yes, reason: _____

Employee's monthly gross salary:	$	Date of change in salary:	/ /
Monthly salary prior to current:	$	Date of change in salary:	/ /

To the best of my knowledge the above information is true and accurate.

Timekeeper's Signature: _____ Date: _____