



Underwritten by:
YOSEMITE INSURANCE COMPANY
 P.O. Box 2548, Fort Worth, TX 76113-2548
 Toll Free 800-307-0048 / Fax 800-350-9582
 InsClaims@onemainfinancial.com

Insured's Name: _____ Account/Policy # _____ Claim # _____
 (if available)

Involuntary Unemployment Claim Form

Important Information

For Arizona residents only: "For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

For California residents only: "For your protection California law requires the following to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

For Pennsylvania residents only: "Any person who, with the intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison."

For residents of other states (NOTE: None of these notices apply to Oregon residents.): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

For New York residents only: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation."

Signature

Date

INSTRUCTIONS

1. Send all pages of the claim form, completed, signed and dated by the appropriate parties to the Insurance Claims Department as shown above. For new claims only, if the current employer does not verify employment the full 12 months prior to the effective date of coverage, attach additional statements. If the previous employer(s) isn't willing or able to complete this section, check stubs, a payroll history printout or a work history printout from the State Employment Office or Social Security Office that covers this period, is acceptable.
2. If unemployment is due to layoff or termination, a state employment office Representative must complete the Statement of State Employment Office or Employment Agency section. Copies of state unemployment benefit checks or statements, covering the period of unemployment, may be submitted in lieu of this section.
3. If unemployment is due to strike or labor dispute, a Union Representative must complete the statement of Union Office.
4. Keep a copy for your records. Please be aware email is not considered a secure method of deliver for personal/medical information.

Note: Altered forms cannot be accepted.



UN91L1 (01-07-18) Involuntary Unemployment Claim Form



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Involuntary Unemployment Claim Form - Statement of Insured - To be completed by Customer

Mailing address _____ City _____ State _____ Zip _____

Telephone # _____ Social Security _____

Email address (optional) _____

Date last worked / / Date of hire _____ Hours per week _____

Reason for stopping work

- | | | |
|---|---|---|
| <input type="checkbox"/> Shortage of work | <input type="checkbox"/> Employer Termination | <input type="checkbox"/> Became Disabled |
| <input type="checkbox"/> Non-Weather Related Seasonal Lay-off | <input type="checkbox"/> Weather Related Seasonal Lay-off | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Annual or Regularly-Scheduled Shutdown | <input type="checkbox"/> Self-Employment Ended | <input type="checkbox"/> Quit |
| <input type="checkbox"/> End of Employee Contract with Employer | <input type="checkbox"/> Independent Contractor Ended | <input type="checkbox"/> Military Discharge |
| <input type="checkbox"/> Other _____ | | |

Have you returned to work? _____ If yes, date returned _____ Days per week _____ Hours per day _____
 Yes No

Did you receive Severance pay _____ Vacation pay _____ Sick pay _____ If yes, how long? _____ Date 1st notified of separation _____
 Yes No Yes No Yes No

Are you Not Registered for State Unemployment benefits _____ Reason not registered _____
 Registered but not Qualified for State Unemployment benefits _____ Reason not qualified _____
 Registered with the State Unemployment office and qualified for benefits _____

Date of registration _____ Date 1st payment approved by State Unemployment Office _____

Are you currently employed? Yes No If yes, date of hire? _____ Days per week _____ Hours per day _____

AUTHORIZATION

I authorize any employer or other individual or organization, having any records, files, reports, etc., concerning me to release the information to the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. This Authorization shall remain valid for my entire claim period. However, I have the right to revoke this authorization in writing within one year from the date of my signature. A photocopy of this authorization shall be as valid as the original.

I affirm the information I have provided herein is accurate and complete. Signature below is the Claimant or legal representative.

Signature _____ Date / /





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Involuntary Unemployment Claim Form - Statement of Employer - To be Completed by Employer

Date of hire _____ Date last worked

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Type of employment Full Time Part Time Seasonal
 Temporary Independent Contractor

Typical months worked per year _____ Hours worked per week _____

Was / is the employee under an annual contract? Yes No If yes, as of what date? _____

Did employee receive Severance pay Vacation pay Sick pay If yes, how long? Date 1st notified of separation
 Yes No Yes No Yes No _____

Reason for stopping work

- | | | |
|---|---|---|
| <input type="checkbox"/> Shortage of work | <input type="checkbox"/> Employer Termination | <input type="checkbox"/> Became Disabled |
| <input type="checkbox"/> Non-Weather Related Seasonal Lay-off | <input type="checkbox"/> Weather Related Seasonal Lay-off | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Annual or Regularly-Scheduled Shutdown | <input type="checkbox"/> Self-Employment Ended | <input type="checkbox"/> Quit |
| <input type="checkbox"/> End of Employee Contract with Employer | <input type="checkbox"/> Independent Contractor Ended | <input type="checkbox"/> Military Discharge |
| <input type="checkbox"/> Other _____ | | |

Date the employee was notified of termination _____ Estimated return to work date _____

Has the person experienced previous interruption(s) in employment of 30 days or more? Yes No If yes,

From	Through	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employer representative's signature _____ Date _____

Printed name _____ Title _____

Company name _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____ Telephone # _____ Fax # _____





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Involuntary Unemployment Claim Form - Statement of State Employment Office or Employment Agency - To Be Completed By A State or employment Agency

Copies of state unemployment benefit checks or benefit history, covering the period of unemployment, may be submitted IN LIEU of this section.

Date last worked

Initial registration date

Reason for the unemployment

Has the individual remained actively registered? Yes No

If no, provide dates and reasons for the gaps in registration

Does individual qualify for state unemployment benefits? Yes No

If no, why not?

Did individual have a waiting or disqualification period? Yes No

If yes, reason and dates of waiting or disqualification period

Signature of representative

Date

Printed name

Title

Name of office

Telephone #

Statement of Union Office - To Be Completed By Your Local Union Office

To be completed by your local Union office ONLY if work stoppage is due to general strike, unionized labor dispute or a lockout.

Active member since

Date last worked

Reason for separation from last employer

Date allowed to return to work

Signature of representative

Date

Printed name

Title

Name of office

Telephone #

