



**CITY OF LINCOLN  
EMPLOYER'S  
LONG TERM DISABILITY STATEMENT**

*To be completed by employer.*

Employee's Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (Area Code First) \_\_\_\_\_

Date of hire \_\_\_\_\_ Date last worked \_\_\_\_\_

Cause of disability \_\_\_\_\_

Did disability occur due to a work related injury?  Yes  No

Basic monthly earnings \$ \_\_\_\_\_

Has employee been laid off or was the employment terminated? If so, when? \_\_\_\_\_

Date employee returned to work or date expected to return. \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_