American Payroll and Benefits I, LLC
PO Box 189 Ocala, FL 34478
Phone: 352-624-1999 Fax: 352-342-9356

NO KNOWN LOSS STATEMENT
-REINSTATED EMPLOYEE-

Client Name: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Date: _____

RE: _____ SSN: _____
(EMPLOYEE NAME)

Please reinstate the above named employee effective _____.
(Date Returning to Work)

I certify that this employee has had no losses, claims, or accidents. I further certify that I have no knowledge of any pending or potential reason that could give rise to a claim due to this employee. I acknowledge and understand this employee is not covered under workers compensation or other benefits until this form has been received by American Payroll and Benefits I LLC and is accompanied by a new application, prior to the employee reporting to work.

_____
(OFFICER/OWNER SIGNATURE)

_____
(OFFICE/OWNER PRINTED NAME)

_____
(DATE SIGNED)

American Payroll and Benefits I LLC
Employee Reinstatement Approval

_____
(Authorized Signature)

_____
(Date Received)