WAGE AND SALARY VERIFICATION

DATE:	CLAIMANT:	DATE OF ACCIDENT:	FILE #

EMPLOYER'S NAME AND ADDRESS:

EMPLOYEE'S NAME AND ADDRESS

Social Security No.#

The above named person has applied for benefits as a result of injuries sustained in the above referenced date of accident. We understand this person is your employee or former employee. To assist us in determining benefits that may be due to this person, please provide us with the answers to the following questions. Thank you for your cooperation.

1. Occupation: _____

2. Dates of Employment: From: _____ To: _____

3. Wage and Salary as of
Date of Accident: Per Hour _ $_____ Per Week _ $_____ Per Month _ $_____
No. of Hours Worked: _____Per Day _____ Per Week
No. of Days Worked: _____Per Week

4. Does the Employee work Monday through Friday? _ Yes _ No
If not, Explain_____

5. Dates absent due to accident: First Day Out _____ Date Returned _____
(a) If not consecutive, dates absent: _____
(b) Date of anticipated return: _____

6. Dates absent for other reasons: First Day Out _____ Date Returned _____
(a) Please explain _____

7. Has employee filed claim for benefits under any Worker's Compensation or similar law as a result of this accident?
_ Yes _ No

8. Has employee received, is he receiving or is he entitled to receive benefits under any Worker's Compensation or similar law as a result of this accident?
_ Yes _ No _ Undetermined

9. Name of Worker's Compensation Carrier: _____ Policy No. _____

10. Is employee entitled to benefits under a wage or salary continuation plan? _ Yes _ No

11. Is employee entitled to benefits under any health and/or accident insurance program? _ Yes _ No
If so, name of insurance carrier: _____
What weekly disability income benefits, if any, are provided? _____

12. **If you are self-employed, please attach your tax return(s) for at least two (2) years preceding the date of the accident and any other documentation which supports your claim of loss.**

DATE: _____ SIGNED: _____