WAGE AND SALARY VERIFICATION

_____
COMPANY NAME HERE

DATE	POLICY HOLDER	DATE OF ACCIDENT	CLAIM NUMBER

EMPLOYER'S NAME AND ADDRESS	EMPLOYEE'S NAME AND ADDRESS
TELEPHONE NO.:	SOCIAL SECURITY NO.:

Gentlemen/Ladies:

The above named person has made a claim against our insured as a result of injuries in an accident on the date indicated. We understand this person is your employee or former employee. To assist us in giving favorable consideration to this matter, please provide us with the answers to the following questions.

Please complete and return this report directly to us.

_____
CLAIM DEPT.

1. DATES OF EMPLOYMENT: FROM:_____ THROUGH:_____

2. JOB TITLE OR DESCRIPTION: _____

3A. WAGE OR SALARY AS OF DATE OF ACCIDENT: $_____ □ Per Hour □ Per week □ Per Month

3B. AVERAGE WEEKLY WAGE: $_____ HOURS NORMAL WORK WEEK:_____

4. DATES ABSENT FOLLOWING ACCIDENT: FROM:_____ THROUGH:_____

5. WAS EMPLOYEE PAID WAGES OR SALARY DURING THIS ABSENCE? □ YES, IF "YES", AMOUNT PAID $_____ □ NO

6. IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKERS' COMPENSATION LAW AS A RESULT TO THE ACCIDENT? □ YES □ NO □ UNDETERMINED

DATE:_____, 20____. SIGNED:_____

TITLE:_____