

WAGE AND SALARY VERIFICATION

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER
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EMPLOYEE NAME: _____ EMPLOYER NAME: _____
 ADDRESS: _____ ADDRESS: _____
 CITY, STATE: _____ CITY, STATE: _____
 ZIP CODE: _____ ZIP CODE: _____
 SS#: _____ SUPERVISOR: _____

Dear Employer:

The person named above has applied for benefits under the AUTOMOBILE PERSONAL INJURY PROTECTION LAW as a result of injuries in an automobile accident on the indicated date. We understand this person is your employee or former employee. To assist us in determining any benefits that may be due the applicant, we ask that you provide us with the answers to the following questions.

 CLAIM DEPT.

PLEASE COMPLETE AND RETURN THIS REPORT DIRECTLY TO US

1. DATES OF EMPLOYMENT FROM _____ THROUGH _____
 2. JOB TITLE OR DESCRIPTION _____
 3. WAS EMPLOYEE ENTITLED TO RECEIVE WAGES, SALARY OR OTHER BENEFITS DURING ABSENCE?
 YES NO IF YES, AMOUNT \$ _____
 4. WAGE OR SALARY AS OF DATE OF ACCIDENT \$ _____ per hour _____ per day _____ per month
 5. DAYS ABSENT FOLLOWING ACCIDENT FROM _____ THROUGH _____
 6. IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKMEN'S COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? YES NO UNDETERMINED
- NAME OF WOKMEN'S COMPENSATION INSURER: _____

SIGNED _____
 DATE _____
 TITLE _____