WAGE AND SALARY VERIFICATION

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

EMPLOYEE NAME: _______________________________
ADDRESS: ______________________________________
CITY, STATE:_____________________________________
ZIP CODE: ______________________________________
SS#: ____

EMPLOYER NAME: _________________________________
ADDRESS: _______________________________________
CITY, STATE: _____________________________________
ZIP CODE: _______________________________________
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.

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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 WORKMEN'S COMPENSATION INSURER: ____

SIGNED_____________________________________
DATE_______________________________________
TITLE_______________________________________

Form 1220F
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