WAGE AND SALARY VERIFICATION

DATE:	POLICY HOLDER:	DATE OF ACCIDENT:	FILE NUMBER:

EMPLOYEE'S NAME:	SOCIAL SECURITY NUMBER:
ADDRESS:	

Dear Sir or Madam:
The above named person has applied for benefits under the "No Fault" insurance as a result of injuries in an automobile accident on the date indicated. We understand this person is your employee of former employee. To determine benefits that may be due to the applicant the law requires you to provide us with the answers to the following seven questions, and to return this form promptly.

Thank you for your cooperation.

1. DATES OF EMPLOYMENT FROM:_____ THROUGH: _____

2. DATES OF ABSENCE FOLLOWING ACCIDENT: FROM:_____ THROUGH: _____

3. WAS EMPLOYEE PAID DURING THIS ABSENCE? ☐ YES ☐ NO IF "YES," AMOUNT PAID $_____

4. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN? ☐ YES ☐ NO

5. NAME OF YOUR WORKER'S COMPENSATION INSURER: _____

6. HAS OR WILL A CLAIM BE FILED UNDER ANY WORKER'S COMPENSATION LAW FOR THIS ACCIDENT? ☐ YES ☐ NO

7. SCHEDULE OF WEEKLY EARNINGS FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT:

WEEK			NUMBER OF DAYS WORKED	AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK	GRATUITIES			GROSS EARNINGS
NO.	FROM DATE	TO DATE			MEALS	BOARD	TIPS	
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
TOTAL:								

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

AIS ID 49828

Pursuant to Florida Statute 627.736 (§) "Under penalty of perjury I declare that I have read the foregoing and the information provided above is true to the best of my knowledge and belief."

EMPLOYER _____ **DATE** _____

SIGNED _____ **TITLE** _____