Wage and Salary Verification

Date	Our Policy Holder	Date of Accident	File Number

____
Employee's Name

____
Employee's Address

Sir or Madam:

The above named person has applied for benefits under the _________________ Florida Motor Vehicle No-Fault as a result of injuries in an accident on the date indicated. We understand this person is your employee or former employee. To determine benefits that may be due to the applicant, this 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.

____
Claim's Department

____

____
Address

1. Dates of Employment: From: ________________ Through: ____________________
2. Dates absent 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 Workmen's Compensation Insurer: ____
6. Has or will a claim be filed under any Workmen's Compensation Law for this accident? Yes ____ No ____

7. Schedule Of Weekly Earnings

Week No.	Week		No. of Days Worked	Amount Earned Including Overtime or Extra Work	Gratuities				Gross Earnings
	From Date	To Date			Meals	Board	Tips	All Other	
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 files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employer ____________________ Date ________________ Signed ______________________ Title ________________