WAGE AND SALARY VERIFICATION

Employee's Name:_____

Address: _____

_____

City: _____ State: _____ ZIP Code: _____

1. Occupation: _____

2. Dates of employment: From: _____ Through: _____

3. Earnings during 52-week period to accident: $_____ Gross $_____ Net
   Wages or salary as of date of accident: $ _____ ❑ Per Hour ❑ Per Week ❑ Per Month
   Number of hours worked: _____ Per Day _____Per Week
   Number of days worked: _____ Per Week
   Circle specific days employee is scheduled to work: SU M T W TH F S

4. Dates(s) absent following accident: From: _____Through: _____

5. Are you a covered employer for:
   a. State Temporary Disability ❑ Yes ❑ No ❑ N/A
   b. Private Disability Plan ❑ Yes ❑ No ❑ N/A
   If yes, has the employee filed for benefits under a or b above? ❑ Yes ❑ No ❑ Undetermined
   Name of the Insurer/Disability Plan:_____
   What weekly disability income benefits, if any, are provided? _____

6. Total accumulated days: Sick _____ Vacation _____ Personal _____
   Are the above days required to be used before becoming eligible for the applicable disability plan?
   ❑ Yes ❑ No

7. Has or will a claim be filed under any workers' compensation law for this accident?
   ❑ Yes ❑ No ❑ Undetermined
   If yes, please provide the workers' compensation carrier's:
   Name and Address: _____
   Policy Number: _____
   Phone Number: _____

THE STATE OF PENNSYLVANIA REQUIRES US TO NOTIFY YOU OF THE FOLLOWING:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DATE:_____ SIGNED:_____

TITLE:_____