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 DELAWARE REQUIRES US TO NOTIFY YOU OF THE FOLLOWING:
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DATE:_____ SIGNED:_____

TITLE:_____