

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: S U M T W T H 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 NEW JERSEY REQUIRES US TO NOTIFY YOU OF THE FOLLOWING:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

DATE: _____ SIGNED: _____

TITLE: _____