

# WAGE AND SALARY VERIFICATION

DATE _____	CLAIM NUMBER _____	DATE OF ACCIDENT _____
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EMPLOYEE'S NAME AND ADDRESS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

-FOLD

The above named person has applied for benefits following injuries received in an accident on the date indicated. We understand this individual is or was your employee. To determine wage benefits due, we ask that this form be completed and returned to us in the attached postage paid envelope. A signed authorization for the release of this information is enclosed.

Thank you for your cooperation,

STATE FARM INSURANCE CLAIM OFFICE

\_\_\_\_\_

\_\_\_\_\_

CLAIM OFFICE  
PHONE NO. \_\_\_\_\_

\_\_\_\_\_  
CLAIM REPRESENTATIVE

1. DATES OF EMPLOYMENT: FROM _____, (YEAR) _____ THRU _____, (YEAR) _____	2. DATES ABSENT FOLLOWING ACCIDENT: FROM _____, (YEAR) _____ THRU _____, (YEAR) _____
3. EMPLOYEE'S JOB TITLE _____	4. EMPLOYEE'S JOB DUTIES: _____
5. WAS EMPLOYEE PAID DURING THIS ABSENCE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, AMOUNT \$ _____	6. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>
7. NAME OF YOUR WORKER'S COMPENSATION INSURER: _____	8. HAS OR WILL A CLAIM BE FILED UNDER ANY WORKERS' COMPENSATION LAW FOR THIS ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>

9. SCHEDULE OF WEEKLY EARNINGS – FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT OR ANNUAL SALARY AMOUNT \$ _____								
NO.	WEEKS DATES		NUMBER OF DAYS WORKED	WAGE PAID PER HOUR	NUMBER OF HOURS WORKED	AMOUNT EARNED INCL'ING OVERTIME OR EXTRA WORK	GRATUITIES TIPS –ETC.	GROSS EARNINGS
	FROM	TO						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								

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

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ PHONE NO. \_\_\_\_\_ DATE \_\_\_\_\_  
(PERSON COMPLETING FORM)