WAGE AND SALARY VERIFICATION

NAME OF INSURANCE COMPANY

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

EMPLOYEE'S NAME AND ADDRESS
SOCIAL SECURITY NO.

"Pursuant to Florida Statute 817.234 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 in the third degree."

Gentlemen:

The above named person has applied for benefits under the "No Fault" Insurance as a result of injuries in an automobile accident on the date indidcated. We understand this person is your employee or former employee. To determine benefits that may be due the applicant, this law requires you to provide us with the answers to the following seven questions, and to retun this form promptly.

Thank you for your cooperation.

_____
CLAIM DEPARTMENT

1. DATES OF EMPLOYMENT: FROM: _____ THROUGH _____
2. DATES ABSENT FOLLOWING ACCIDENT FROM: _____ THROUGH _____
3. WAS EMPLOYEE PAID DURING THIS ABSENCES? 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 -- FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

WEEK			NO. OF DAYS WORKED	AMT. EARNED INCL. OVERTIME/ EXTRA WORK	GRATUITIES				GROSS EARNINGS
#	FROM DATE	TO DATE			MEALS	BOARD	TIPS	OTHER	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10									
11									
12									
13									
TOTAL									

Pursuant to Florida Statute 627.736 [6] "Under penalty of perjury I declare that I have read the foregoing and the information provided is true to the best of my knowledge and belief."

EMPLOYER _____ DATE _____ SIGNED _____ TITLE _____