

WAGE AND SALARY VERIFICATION

NAME OF
INSURANCE
COMPANY:

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
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EMPLOYEE'S NAME AND ADDRESS
SOCIAL SECURITY NO.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF 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 indicated. 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 return this form promptly.

Thank you for your cooperation.

CLAIM DEPARTMENT

DATES OF EMPLOYMENT: FROM _____ THROUGH _____

DATES ABSENT FOLLOWING ACCIDENT: FROM _____ THROUGH _____

WAS EMPLOYEE PAID DURING THIS ABSENCE? YES NO IF "YES," AMOUNT PAID \$ _____

IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN? YES NO

NAME OF YOUR WORKMEN'S COMPENSATION INSURER _____

HAS OR WILL A CLAIM BE FILED UNDER ANY WORKMEN'S COMPENSATION LAW FOR THIS ACCIDENT? YES NO

SCHEDULE OF WEEKLY EARNINGS - FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

WEEK	WEEK		NO. OF DAYS WORKED	AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK	GRATUITIES				GROSS EARNINGS
	FROM DATE	TO DATE			MEALS	BOARD	TIPS	ALL OTHER	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

TOTAL

Pursuant to Florida Statutes §627.736(6), "Under penalty of perjury I declare that I have read the foregoing and the information provided above is true to the best of my knowledge and belief."

EMPLOYER _____ DATE _____ SIGNED _____ TITLE _____