WAGE AND SALARY VERIFICATION FORM

Date: __________ Our Policyholder: __________________ Date of Accident: ______________

TO: __________________________ Employee Name: ________________________
(Employer name)

Employer Address: Employee Address:

______________________ ____________________

Social Security: ____________________

Sir or Madam:

The above-named person has applied for benefits under the **MASSACHUSETTS PERSONAL INJURY PROTECTION LAW** as a result of injuries sustained in an automobile accident on the date indicated. We understand this person is your employee or former employee. To assist us in determining benefits that may be due the applicant, please provide us with the answers to the following questions.

Thank you for your cooperation.

1. Occupation: ____
2. Dates of Employment: FROM: _______________ THROUGH: ____________
3. Gross Earnings for 52-Week Period before Accident: $__________________________
4. Wage or Salary as of Date of Accident: a. $________________________________
   b. Number of Days Worked per Week: ___________
5. Dates Absent Following Accident: a. Date Disability Began: ____________________
   b. Date Returned to Work: ___________________
6. Was Employee Paid During this Absence? Yes No If "Yes", amount paid: _____________
7. Is Employee Entitled to Benefits Under a Wage or Salary Continuation Plan? Yes No
   a. If "Yes", Amount Paid or Available: $________________ ☐ per week ☐ per month
8. Has Employee Filed a Claim for Benefits Under Any Worker's Compensation Law as a result of this Accident? Yes No
9. Has Employee Received, is (s)he receiving or is he entitled to receive Benefits Under any Worker's Compensation Law as a result of this Accident? Yes No Undetermined

Dated: ________________________ Signed: ____________________________
Name

Title: ____________________________
Print Name and Title