# WAGE AND SALARY VERIFICATION

| DATE | POLICY HOLDER | DATE OF ACCIDENT | FILE NUMBER |
|---|---|---|---|
| | | | |

TO:
RE: Employment Verification
ATTN: Human Resources

**The above named person has applied for benefits under the MINNESOTA NO-FAULT AUTOMOBILE INSURANCE ACT as a result of injuries in an automobile accident on the date indicated above. We understand this person is your employee or former employee. To assist us in determining benefits that may be due to the applicant, please provide us with the answer to the following questions. A signed authorization for the release of this information is enclosed.**

1. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____
2. JOB TITLE OR DESCRIPTION: _____
3. WAGE OR SALARY AS OF DATE OF ACCIDENT: $_____/HOUR
4. NORMAL WORK SCHEDULE:

| | START | FINISH | TOTAL HRS |
|---|---|---|---|
| SUNDAY | | | |
| MONDAY | | | |
| TUESDAY | | | |
| WEDNESDAY | | | |
| THURSDAY | | | |
| FRIDAY | | | |
| SATURDAY | | | |

5. WEEKLY EARNINGS – 8 WEEKS PRIOR TO ACCIDENT (IF WEEKLY SCHEDULE ABOVE VARIES)

| WEEKS | | | # DAYS WORKED | HOURLY WAGE | HOURS WORKED | TIPS, O.T. ETC. | GROSS EARNINGS |
|---|---|---|---|---|---|---|---|
| NO. | FROM | TO | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |

6. DATES ABSENT SINCE ACCIDENT: FROM: _____ THROUGH: _____
   CONTINUING? _____
7. REASON FOR ABSENCE: _____
8. WAS EMPLOYEE PAID WAGES DURING ABSENCE? YES/NO AMT PAID: $_____
9. IS EMPLOYEE ENTITLE TO RECEIVE BENEFITS UNDER ANY WORKER'S COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? ___ YES ____ NO
   NAME OF WORKER'S COMPENSATION CARRIER: _____

SIGNATURE:_____ DATE: _____
TITLE: _____ PHONE: _____