WAGE AND SALARY VERIFICATION

Date	Our Policyholder	Date of Accident	File Number
			Employee's Name and Address

To Whom It May Concern:

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 if 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.

1.	Dates of Employment:	From:	Through:
2.	Dates absent following accident:	From:	Through:

		•	1	•
Was employee paid during absence?	Yes	No	If Yes. A	mount paid?

- 3. Is employee entitled to benefits under a wage or salary continuation plan? Yes_____ No_____ 4.
- 5.
- 6. Yes_____ No _____
- SCHEDULE OF WEEKLY EARNINGS For 13 Weeks Prior to Date of Accident 7.

Wk. No <u>From</u>	<u>To</u>	No of Days Worked	Amount Earned Including Overtime or Extra Work					Gross Earning
Date	Date			Meals	Board	Tips	Other	
1.								
2.								
3.								
4.								

5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
TOTAL							

Employee	D-4-	Clause 1	T:41-
Employer	Date	Signed	Intie

(Pursuant to Florida Statute Section 17.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.) Pursuant to Florida Statute Section 27.736(6), under penalty of perjury, I declare that I have rad the foregoing and that the information provided above is true to the best of my knowledge and belief.

AUTHORIZATION

I, the undersigned client hereby authorize my employer to give the above information to the Law Office of Singer, Farbman & Associates, my attorneys and/or my insurance carrier.

EMPLOYEE/CLIENT