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:_____
3. Was employee paid during absence? 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 Workmen's Compensation Law for this accident?
   Yes_____ No _____
7. SCHEDULE OF WEEKLY EARNINGS - For 13 Weeks Prior to Date of Accident

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

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

TOTAL

Employer_____ Date_____ Signed_____ Title_____

(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