MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

WAGE, SALARY AND BENEFITS VERIFICATION

Date	Our Policyholder	Date of Accident	File Number

Employee's Name and Address
Social Security No.

The above named person has applied for benefits under the MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE 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 this person, please provide us with the answers to the following questions. You are required to provide this information in accordance with the **MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, P.A. 294** of the public acts of 1972.

Thank you for your cooperation.

_____
Claim Department

1. Job Title and Description of Duties: _____

_____

2. Dates of Employment: From _____ Through _____

3. Employment Status: ☐ Full time ☐ Part-time ☐ Seasonal ☐ Lay-off ☐ Leave of Absence ☐ Termination

4. Circle days worked in average week: S M T W T F S

   Hours worked per day: _____ Hours worked per week: _____

5. Income earned last calendar year: $_____

6. Wages: ☐ Hourly $_____ (Include COLA & Shift premium) ☐ Salary $_____

   ☐ Other (Specify) $_____

7. Was employee working overtime at the time of disability? ☐ Yes ☐ No

8. If yes, average hours of overtime per week: _____

   Rate of pay for overtime: $_____

9. Did employee's injury arise out of and in the course of his/her employment?

   ☐ Yes ☐ No

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(see reverse side)

10. If yes, give name of workers' compensation insurance carrier:

_____

10a. Please indicate the total amount of time lost from his/her employment: _____

11. Is employee covered by a wage or salary continuance plan? ☐ Yes ☐ No

If yes, give name and address of provider of benefits and describe the nature of the plan:_____

_____

Policy Number: _____

When do benefits begin? _____

Amount payable per week: $_____

How long benefits payable? _____

12. Is employee covered by a medical benefits plan? ☐ Yes ☐ No

If yes, give name and address of provider and policy number: _____

_____

Policy Number: _____

Date:_____

_____
Print Name & Title

_____
Signature

Phone:_____

For your protection Michigan law requires the following to appear on this form:

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.