

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    Seasonal    Leave of Absence  
 Part-time    Layoff    Termination

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

5. Length of Disability: From \_\_\_\_\_ Through \_\_\_\_\_

6. Income earned last calendar year: \$ \_\_\_\_\_

7. Wages:  Hourly \$ \_\_\_\_\_ (Include COLA & Shift Premium)

Salary \$ \_\_\_\_\_  Other (Specify) \$ \_\_\_\_\_

8. Was employee working overtime at the time of disability?    yes    no

9. If yes, average hours of overtime per week: \_\_\_\_\_

Rate of pay for overtime: \$ \_\_\_\_\_

10. Did employee's injury arise out of and in the course of his/her employment?    yes    no

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

\_\_\_\_\_

12. 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? \_\_\_\_\_

13. Is employee covered by a medical benefits plan? yes no

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

\_\_\_\_\_

Policy # : \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Print Name & Title

\_\_\_\_\_

Signature

Phone: \_\_\_\_\_