Instructions

If you missed time from work because of injuries sustained in the accident and you intend to file a claim for medical or wage loss expenses, you must have your employer complete the Wage and Salary Verification form.

You will need to print this form, fill out the current date, your name, the date of the accident and your claim number, and give the form to your employer. Your employer will need to complete the form and return it to GEICO.

(Form Below)

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
WAGE AND SALARY VERIFICATION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NUMBER

____
Employee’s Name

____

____
Employee’s Address

Dear Sir or Madam:

The above named person sustained injuries as a result of an automobile accident on the date indicated. We understand this person is your employee or former employee. To determine what monies may be due to the injured party, please provide us with responses to the following questions, and return this form promptly. Thank you for your cooperation.

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
CLAIMS DEPARTMENT
Attn: Region IV Claims, PO Box 35
Macon, GA 31294-9643

1. Occupation: ____
2. Date of Employment: From: _______________ Through: _______________
3. Dates absent following accident: From: _______________ Through: _______________
4. Was employee paid during this absence? Yes___ No___ If Yes, Amount Paid $_____________
5. Is employee entitled to benefits under a wage or salary continuation plan? Yes___ No___
6. Name of your Workers’ Compensation Insurer: ____
7. Has or will a claim be filed under any Workers’ Compensation Law for this accident? Yes___ No___

8. SCHEDULE OF WEEKLY EARNINGS — FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

WEEK NO.	WEEK		NO. OF DAYS WORKED	AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK	ADDITIONAL COMPENSATION				GROSS EARNINGS
	FROM DATE	TO DATE			MEALS	BOARD	TIPS	ALL OTHER	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
TOTAL									

For your protection, California law requires the following statement to appear on this form: "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

EMPLOYER: _________________________ DATE: __________ PHONE #: __________________ TITLE: ________________

SIGNED: ____ PRINT NAME_____________________________________