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 **Employer's Wage Verification Report** form.

(Form Below)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
EMPLOYER'S WAGE VERIFICATION REPORT

Name and Address of Insurer or Self-Insurer

Government Employees Companies
750 Woodbury Road
Woodbury, New York 11797

Name, Address & Phone Number of Insurer's Claim Representative

GEICO
PO BOX 9507
Fredericksburg, VA 22403-9515

Date	Policyholder	Policy Number	Date of Accident	Claim Number

Name and Address of Employer

Employee's Name and Address

Social Security No.

DEAR EMPLOYER:

The above named person has applied for benefits under the NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW) as a result of injuries sustained in a motor vehicle 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 the applicant, please provide us with the answers to the following questions.

PLEASE COMPLETE AND SUBMIT THIS FORM TO OUR CLAIMS REPRESENTATIVE AS SOON AS POSSIBLE.
PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 90 DAYS AFTER WORK LOSS WAS FIRST INCURRED.

Thank you for your cooperation.

_____
CLAIM REPRESENTATIVE

1. EMPLOYEE'S OCCUPATION:_____

2. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____

3. GROSS EARNINGS DURING 52 WEEK PERIOD PRIOR TO ACCIDENT: $ _____
   WAGE OR SALARY AS OF DATE OF ACCIDENT: $ _____ HOURLY $_____ WEEKLY $_____ MONTHLY
   NUMBER OF HOURS NORMALLY WORKED PER DAY _____ NUMBER OF DAYS NORMALLY WORKED PER WEEK _____

4. DATES ABSENT FOLLOWING ACCIDENT:
   FIRST DAY ABSENT FROM WORK _____ DATE RETURNED TO WORK _____

5. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKER'S COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO ☐ UNDETERMINED
   WORKER'S COMPENSATION INSURER _____
   ADDRESS _____
   POLICY NUMBER _____

6. HAS EMPLOYEE RECEIVED, IS EMPLOYEE RECEIVING OR IS EMPLOYEE ENTITLED TO RECEIVE NEW YORK STATE DISABILITY BENEFITS AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO ☐ UNDETERMINED
   IS THE EMPLOYEE REQUIRED TO PAY FOR DBL COVERAGE THROUGH PAYROLL DEDUCTION? ☐ YES ☐ NO
   NYS DISABILITY INSURER _____
   ADDRESS _____
   POLICY NUMBER _____

7. WAS OR WILL EMPLOYEE BE PAID BY EMPLOYER FOR THIS ABSENCE FROM WORK? ☐ YES ☐ NO
   IF ANSWER TO QUESTION 7 IS "YES" PLEASE ANSWER QUESTIONS 8, 9, 10 AND 11.

8. HOW MUCH WAS OR WILL EMPLOYEE BE PAID $ _____ WEEKLY $_____ MONTHLY

9. WILL THE EMPLOYEE BE REQUIRED TO REIMBURSE YOU ANY OF THE ABOVE AMOUNT? ☐ YES ☐ NO

(CONTINUED ON REVERSE SIDE)

EMPLOYER'S WAGE VERIFICATION REPORT

10. WILL THE EMPLOYEE LOSE ACCUMULATED LEAVE CREDITS AS A RESULT OF THE FOREGOING PAYMENT?
☐ YES ☐ NO

11. WILL THE EMPLOYEE'S ELIGIBILITY FOR FUTURE WAGE BENEFITS BE AFFECTED BY PAYMENTS INDICATED IN QUESTION 8 ABOVE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____	_____	_____
PRINT NAME	TITLE	PHONE NO.
_____	_____	_____
SIGNATURE	FEDERAL EMPLOYER I.D. NO	DATE