MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
WAGE, SALARY AND BENEFITS VERIFICATION

DATE		DATE OF ACCIDENT	FILE NUMBER

EMPLOYEE'S NAME AND ADDRESS

SOCIAL SECURITY NUMBER

The above named person has applied for benefits under the MICHIGAN MOTOR VEHICLE NO-FAULT 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;

JOB TITLE AND DESCRIPTION OF DUTIES:

DATES OF EMPLOYMENT: FROM THROUGH	EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART-TIME ☐ TERMINATION ☐ LAY-OFF ☐ SEASONAL ☐ LEAVE OF ABSENCE	DATES ABSENT FOLLOWING ACCIDENT FROM TO
CIRCLE DAYS WORKED IN AVERAGE WEEK: S M T W T F S	HOURS WORKED PER DAY:	HOURS WORKED PER WEEK:
INCOME EARNED LAST CALENDAR YEAR:	WAGES: ☐ HOURLY $ ☐ SALARY $ ☐ (Include COLA & shift premium) ☐ Other (Specify)	
WAS EMPLOYEE WORKING OVERTIME AT THE TIME OF DISABILITY? ☐ YES ☐ NO	IF YES, AVERAGE HOURS OF OVERTIME PER WEEK:	RATE OF PAY FOR OVERTIME: $
DID EMPLOYEE'S INJURY ARISE OUT OF AND IN THE COURSE OF HIS/HER EMPLOYMENT? ☐ YES ☐ NO	IF YES, GIVE NAME OF WORKERS' COMPENSATION INSURANCE CARRIER:	
IS EMPLOYEE COVERED BY A WAGE OR SALARY CONTINUANCE PLAN? ☐ YES ☐ NO	IF YES, GIVE NAME AND ADDRESS OF PROVIDER OF BENEFITS AND DESCRIBE NATURE OF PLAN:	
POLICY NUMBER:	WHEN DO BENEFITS BEGIN?	
AMOUNT PAYABLE PER WEEK: $	HOW LONG BENEFITS PAYABLE?	
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: _____

PHONE