FAX: (502) 589-2826

DECAMILLIS & MATTINGLY, PLLC
WAGE AND SALARY VERIFICATION

Date	Our Policy Holder	Accident Date	File Name

Employee's Name and Address:

TO WHOM IT MAY CONCERN: The above-named person has applied for benefits under the Kentucky No-Fault Law as a result of injuries sustained in an automobile accident on the date indicated above. 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:

1. Occupation	2. Dates of Employment
3. Wage or Salary (Gross) as of Date of Accident: $__________ per hour $__________ per week $__________ per month	4. Average Number of Hours Worked per Week: Average Overtime Hours:
5. Dates Absent Due to This Accident:	6. If not Consecutive, Dates Absent or Total Number of Days:

7. Has Employee Filed Claim for Benefits Under any Workers' Compensation or Similar Law as a Compensation Act or Similar State or Federal Law as a Result of This Accident?
Yes c No c If Yes, Name of Insurer:

8. Has Employee Received, is he Receiving, or is he Entitled to Receive Benefits Under any Workers' Compensation Act or Similar State or Federal Law as a Result of This Accident?

Yes c No c Undetermined c If "Yes", Name of Insurer:

Social Security Number: Date of Return to Work:

Partial Status c Full Status c

Signature: ______________________ Title: ______________________

Print name: ______________________

Name of Company: ______________________ Address: ______________________

Date: ______________________ Phone number: ______________________