DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

To: _____
_____
_____
_____

State Agency: _____
Claimant: _____
R.M. File Number: _____
Date of Accident: _____

WAGE AND SALARY VERIFICATION

The above claimant filed claim for benefits under the "No Fault" automobile insurance law for injuries arising out of an automobile accident on the above date. Our records indicate this claimant is your employee or former employee. In order to determine benefits due those injured in motor vehicle accidents, the law requires you provide the following information. Attached is authorization. When completed, return to the Division of Risk Management.

Dates Employed _____ To_____ Entitled to Benefits Under a Wage/Salary Continuation Plan? Yes ☐ No ☐

Dates Absent Following Accident: _____ To:_____ Amount Paid Employee During Absence: $_____

Name and Address of Your Workers' Compensation Carrier:

_____

Has or Will a Claim Be Filed Under Any Workers' Compensation Law For This Accident? ☐ Yes ☐ No

If Yes: Claim #:_____ Policy #: _____

SCHEDULE OF WEEKLY EARNINGS - FOR 13 WEEKS PRIOR TO ACCIDENT DATE

WEEK #	WEEK FROM DATE	WEEK TO DATE	NO. OF DAYS WORKED	EARNED INCOME OVERTIME OR EXTRA WORK	GRATUITIES MEALS	GRATUITIES BOARD	GRATUITIES TIPS	GRATUITIES OTHER	GROSS
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
AVERAGE WEEKLY EARNINGS									

COMMENTS: _____

_____

Pursuant to Section 817.234, F.S., Any Person Who Knowingly and With Intent to Defraud or Deceive Any Insurance Company, Files a Statement of Claim Containing Any False, Incomplete or Misleading Information is Guilty of a Felony of the Third Degree.

Employer: _____ Date: _____

Signature: _____ Title: _____

RETURN TO: Division of Risk Management
Bureau of State Liability & Property Claims
200 East Gaines Street
Tallahassee, FL 32399-0300

DFS-D0-283
Effective 07/23
Rule 69H-2.009, F.A.C.