

More Than Just Insurance.



PO Box 900  
Lincroft, NJ 07738

High Point Preferred Insurance Company  
High Point Safety and Insurance Company  
High Point Property and Casualty Insurance Company  
Palisades Safety and Insurance Association  
Palisades Insurance Company  
Palisades Property and Casualty Insurance Company

**WAGE & SALARY AUTHORIZATION FORM**

Date	Our Policyholder	Policy Number	Date of Accident	Claim Number
Applicant's Name		Phone No. (Home) ( )	Business ( )	
Applicant's Address (No., Street, City or Town, State and Zip Code)			Date of Birth	Social Security No.
The above named person has applied for benefits as a result of injuries 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 the applicant, PLEASE PROVIDE US WITH THE ANSWERS TO THE FOLLOWING QUESTIONS. PLEASE COMPLETE AND RETURN THIS REPORT DIRECTLY TO US.				
Dates of Employment From: _____ Through: _____			Job Title or Description	
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Termination				
Circle days worked in average week: S M T W T F S			(Gross) (Net) income earned last calendar year Hours worked per day _____ per week _____	
Wage or Salary as of Date of Accident (Include COLA + shift premium) \$ _____ <input type="checkbox"/> Per Hour <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month			What are the normal hours worked by your employee? To: _____ From: _____	
Did the employee normally work overtime when available? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee working OT at time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			How many hours on the average were worked by the employee when overtime was available? Rate of pay for overtime \$ _____	
Last day worked prior to this accident:			Dates absent following accident? To: _____ From: _____	
Did the employee have a doctor's excuse for his absences? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What was the doctor's reason for the excuse from work and were there any restriction put on the employee? _____ _____				
Did the employee have a history of absences due to any medical problems? (Prior to accident?) _____ _____ _____				
Has employee returned to work since that date? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, when?			Is he/she now performing his/her regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was any portion of this absence during a vacation period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date(s) of vacation				
If no, reason stated for restrictions				

Did employee lose any earnings due to this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what amount was lost?      \$	
Was employee paid wages during this absence? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, is employee covered by a wage or salary continuance or state disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please give name and address of provider of benefits and describe the nature of the plan: Policy Number:	
Is there a waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when do benefits begin?
Amount payable per week?	How long are benefits payable?
Is employee covered by a medical benefits plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give name and address of provider and policy number:
Has employee filed claim for benefits under any Worker's Compensation Law as a result of this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined	
If yes, name of Worker's Compensation Carrier	
Has employee received, is he receiving or is he entitled to receive benefits under any Worker's Compensation Law as a result of this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined	
<b>Signature</b>	<b>Date</b>
<b>Title</b>	<b>Phone Number</b>