Twin Lights INSURANCE

PO Box 923
Lincroft, NJ 07738

Underwritten by
Twin Lights 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: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Layoff ☐ Leave of Absence ☐ 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) $ ☐ Per Hour ☐ Per Week ☐ Per Month	What are the normal hours worked by your employee? To: From:
Did the employee normally work overtime when available? ☐ Yes ☐ No Was employee working OT at time of disability? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

If yes, when? Is he/she now performing his/her regular duties? ☐ Yes ☐ No

Was any portion of this absence during a vacation period? ☐ Yes ☐ No If yes, date(s) of vacation

If no, reason stated for restrictions

Did employee lose any earnings due to this accident? ☐ Yes ☐ No

If yes, what amount was lost? $

Was employee paid wages during this absence? ☐ Yes ☐ No

If yes, is employee covered by a wage or salary continuance or state disability plan? ☐ Yes ☐ 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? ☐ Yes ☐ No	If yes, when do benefits begin?
Amount payable per week?	How long are benefits payable?
Is employee covered by a medical benefits plan? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Undetermined	
Signature	**Date**
Title	**Phone Number**