THE PREMIER INSURANCE COMPANY OF MASSACHUSETTS

WAGE AND SALARY VERIFICATION

WORCESTER OFFICE - *One Chestnut Place, 10 Chestnut Street, Suite 300, Worcester, MA 01608*
DANVERS OFFICE - *Northwoods Business Park, 199 Rosewood Drive, Danvers, MA 01923*
FALL RIVER OFFICE - *99 South Main Street, PO Box 71, Fall River, MA 02722*

DATE _____ OUR POLICYHOLDER _____
DATE OF ACCIDENT _____ FILE NUMBER _____

EMPLOYER'S NAME _____
ADDRESS _____

EMPLOYEE'S NAME _____
ADDRESS _____
SOCIAL SECURITY NO. _____

The above named person has applied for benefits under the MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS 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 the applicant, please provide us with the answers to the following questions.

Thank you for your cooperation.

1. OCCUPATION: _____
2. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____
3. GROSS EARNING DURING 52 WEEK PERIOD PRIOR TO ACCIDENT: $_____
4. WAGE OR SALARY AS OF DATE OF ACCIDENT: A) $_____ PER WEEK _____ PER MONTH _____
   B) USUAL NUMBER OF DAYS WORKED PER WEEK: _____
5. DATES ABSENT FOLLOWING ACCIDENT: A) DATE DISABILITY BEGAN: _____
   B) DATE RETURNED TO WORK: _____
6. WAS EMPLOYEE PAID DURING THIS ABSENCE? YES _____ NO _____ IF "YES", AMOUNT PAID: $_____
7. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTIUATION PLAN? YES _____ NO _____
   - IF "YES" AMOUNT PAID OR AVAILABLE: $_____ PER WEEK _____ PER MONTH _____
   - IF "YES", ARE CASH OR ADDITIONAL RETIREMENT CREDITS REDUCED UNDER YOUR PLAN BY AMOUNT OF BENEFITS PAID? YES _____ NO _____
8. HAS EMPLOYEE FILED CLAIM FOR BENEFITS UNDER ANY WORKERS' COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? YES _____ NO _____
9. HAS EMPLOYEE RECEIVED, IS RECEIVING OR IS ENTITILED TO RECEIVE BENEFITS UNDER ANY WORKERS' COMPENSATION LAW AS A RESULT OF THIS ACCIDENT? YES _____ NO _____ UNDETERMINED _____
10. IS EMPLOYEE ELIGIBLE FOR ANY INDIVIDUAL/GROUP HEALTH INSURANCE/HMO/OTHER BENEFITS? YES _____ NO ____

DATE _____ PRINT TITLE & NAME _____

TELEPHONE NO. (_____)_____ SIGNATURE _____