

# WAGE STATEMENT

FOR CARRIER'S DATE STAMP
REC'D BY CARRIER

PLEASE PRINT OR TYPE

EMPLOYEE NAME		SOCIAL SECURITY NUMBER		DATE OF ACCIDENT (mm/dd/yyyy)	
EMPLOYER NAME & ADDRESS: Street: _____ City: _____ State: _____ Zip: _____		CONCURRENT EMPLOYER NAME & ADDRESS (If applicable): Street: _____ City: _____ State: _____ Zip: _____		ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE?  YES      NO	
TELEPHONE		TELEPHONE		SIMILAR EMPLOYEE'S NAME:	
EMPLOYEE'S CUSTOMARY WORK WEEK: <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>		EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK: <small>(ex. 5 days / week)</small>		EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK: <small>(ex. 40 hours / week)</small>	
				OCCUPATION OF SIMILAR EMPLOYEE	

**NOTICE TO EMPLOYER:** Complete the form as fully as possible and submit it to your carrier within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your carrier within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

<u>Please list wages earned for the 91 day period immediately preceding the accident.</u> DO NOT combine wages of two or more employees.					GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY	
WEEK NO.	WEEK		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK		GROSS PAY	HEALTH INSURANCE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
RETURN THIS FORM TO: <small>(Carrier Name, Address &amp; Telephone#)</small>					TOTAL	WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?	
<b>FHM Insurance Company</b> Serviced By: UNITED SELF INSURED SERVICES P.O. Box 616648, Orlando, FL 32861-6648 407-351-1212 888-346-3461					TOTAL FRINGE BENEFITS		\$
					TOTAL OF GROSS PAY, GRATUITIES AND FRINGES		\$
					(FOR CARRIER USE ONLY)		AWW      COMP RATE

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information, is guilty of a felony of the third degree.

PREPARER'S NAME	TELEPHONE	DATE (mm/dd/yyyy)
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