

**EMPLOYEE EARNINGS REPORT**

CARRIER RECEIVED DATE

**NOTE:**

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.

<b>I. IDENTIFICATION OF PARTIES (To be completed by requesting party.)</b>		
EMPLOYEE'S NAME (First, Middle, Last)	EMPLOYEE'S SOCIAL SECURITY NUMBER	DATE OF ACCIDENT
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CARRIER NAME & ADDRESS

<b>II. NOTICE TO EMPLOYEE</b>	
THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.	
TIME PERIOD TO BE REPORTING <b>FROM</b> <b>TO</b>	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION? <input type="checkbox"/> <b>YES</b> (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) <input type="checkbox"/> <b>NO</b> (IF NO, SIGN, DATE AND RETURN)

IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

<b>III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II?</b> <input type="checkbox"/> <b>YES</b> (IF YES, COMPLETE INFORMATION BELOW) <input type="checkbox"/> <b>NO</b>			
PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED FROM      TO	TOTAL GROSS EARNINGS

<b>IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF EMPLOYED?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>		BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE	
DATES SELF EMPLOYED FROM      TO	WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF EMPLOYED FROM      TO	WAGES, INCOME OR BENEFITS RECEIVED

<b>V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS</b> <input type="checkbox"/> <b>YES</b> (IF YES, STATE AMOUNTS) <input type="checkbox"/> <b>NO</b>		
TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS

<b>VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME OR BENEFITS FROM ANY SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another carrier, etc? Attach additional documentation if necessary.</b> <input type="checkbox"/> <b>YES</b> (IF YES, STATE AMOUNTS) <input type="checkbox"/> <b>NO</b>		
SOURCE OF WAGES, INCOME OR BENEFITS	PERIOD BENEFITS RECEIVED FROM      TO	TOTAL AMOUNT

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.

I HAVE REVIEWED, UNDERSTAND AND ACKNOWLEDGE THE ABOVE. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

<b>VII. RETURN TO (to be completed by requesting party):</b>		
REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE	