Chesapeake Employers Insurance™
Your workers' compensation specialist

Statement of Wage Information

Employer:	Injured Employee's Name:	
Chesapeake Employers' Claim Number:	Date of Injury:	WCC Claim Number (If known):

Please list the employee's **weekly gross earnings** for each of the **14 weeks immediately prior to the date / week of the accident.** Please do not include wages for the date of injury.

Week Number	Week Ending Month / Day / Year	Gross Salary (Include all overtime)	Additional Income (if applicable)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

If this employee was given free rent, lodging, board, tips, or other allowances in addition to the above gross salary, please write the weekly value of that in the **"Additional Income"** column.

Name of person completing form _____ Signature of person completing form _____ Date completed _____

Please return this completed and signed form by email to the assigned claims adjuster's email if known. You can also fax the completed and signed form to your claims adjuster via fax at 410-494-2122. Please call your Chesapeake Employers' claims adjuster at 1-800-264-4943 if you have any questions. Thank you.