Chesapeake Employers Insurance
Your workers' compensation specialist

Statement of Wage Information

Employer:	Date Prepared:	Injured Employee's Name:
Injured Employee's SSN:	Date of Injury:	Chesapeake Employers' Claim Number:

Please list the employee's **weekly gross earnings** for each of the **14 weeks immediately prior to the date / week of the accident.**

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 claimant 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 form to your claims representative via fax at 410-494-2122. Please call your Chesapeake Employers' claims representative if you have any questions. 1-800-264-4943. Thank you.