



Injured worker name	Date of injury	Claim number
Injured worker email address	Injured worker contact number	

Instructions

- If you are submitting copies of payroll check stubs or other proof of earnings provided to you by your current employer, then do not complete this form. If you are not submitting copies of payroll check stubs or other proof of earnings, complete this form as indicated below for submission of earnings for the payment of wage loss compensation.
- If BWC is processing your claim, fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.
- If a self-insuring employer is processing your claim, send this form directly to your employer.

To be completed by the injured worker

I am requesting working wage loss benefits from (provide specific dates) _____ to _____ and submitting the following evidence from my employer in support of this request.

With your permission, BWC may assist you in obtaining clarification of the reported earnings below, if necessary (check one of the options below).

- BWC may contact the employer listed below to obtain clarification of the reported earnings information.
- BWC may not contact the employer listed below to obtain clarification of the reported earnings information.

I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Injured worker's signature	Date
----------------------------	------

To be completed by the employer

Provide earnings information based on pay period begin and end dates, not payment/check dates. Include all gross earnings for the injured worker prior to any deductions such as for taxes, garnishment, insurance or employee contributions to retirement programs.

Employer name		Employer phone number	
Address	City	State	Nine digit ZIP code

Pay period begin date: _____ Pay period end date: _____ Gross earnings: _____

Pay period begin date: _____ Pay period end date: _____ Gross earnings: _____

Pay period begin date: _____ Pay period end date: _____ Gross earnings: _____

Pay period begin date: _____ Pay period end date: _____ Gross earnings: _____

Does the payment information above include bonuses, commissions, allowances or other payments in addition to regular earnings?

Yes or No

If yes, please provide specific details about the payment in the comment box below, including the period over which the payment was earned.

You may also provide other information you wish to have considered in the calculation of wage loss compensation in the space below.

Comments:

I certify the information provided is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by the BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature of the person completing this report:	Title:	Date:
---	--------	-------