RETAIL ASSOCIATION SERVICES Inc.

Claim # : _____

Worker's Name : _____

WORKER WAGE AND EMPLOYMENT INFORMATION

Worker's Job Title: _____

Was the worker hired in this position to work on a continuous basis? _____ Yes _____ No

Number of hours worked per day: _____ **Days worked per week:** _____

******* If this worker's schedule varies, please provide wage history for one year prior to date of injury so that the average number of hours per day and days per week can be determined. *******

Rate of pay on day of injury: $ _____ per _____ hour _____ day _____ month

Does the worker receive any of the following types of wages/compensation? (Check all that apply.)

_____ **Multiple rates of pay.**
Average daily earnings for all multiple rates of pay: $ _____

_____ **Commission.**
Amount $ _____ per _____ day _____ week _____ month

_____ **Units of work.**
Average daily earnings for all units of work: $ _____

_____ **Overtime.**
Number of regular overtime hours:
_____ per _____ day _____ week _____ month

_____ **Bonus.**
Bonus for the period of one year prior to date of injury. Amount $ _____

_____ **Tips (reported to the IRS).**
Amount $ _____ per _____ day _____ week _____ month

_____ **Housing, Board, and/or Fuel.** (Fuel refers to electrical, gas, and/or oil included as part of housing)
Amount $ _____ per _____ day _____ week _____ month

Did you pay for health care benefits (medical, dental, and/or vision only) for the worker and/or the worker's family at the time of injury?

_____ Yes _____ No

Are the health care benefits managed by a trust or union?

_____ No _____ Yes (Please provide the name and phone number of the Union/Trust):

_____

What amount did you pay for the health care benefits (medical, dental and vision)?
(Do not include pensions, disability insurance or other considerations)

Amount $ _____ per _____ hour _____ month

Has employer-paid health care coverage ended?

_____ No _____ Yes, what was the last date covered? _____

If payment for health care benefits are on-going but there is an anticipated coverage end date, please provide the date: _____