Claim No.
Insured:
Date of Loss:
Claimant:

Church Mutual Insurance Company, S.I.
3000 Schuster Lane, P.O. Box 342
Merrill, WI 54452-0342
Telephone No. (800) 554-2642, Option 2
Fax No. (715) 539-4651
www.churchmutual.com

WAGE STATEMENT

Report of Employee's Gross Wages for Period of _____ Weeks _____ Days

If possible, state employee's past wages for one year previous to date of injury.

Date of Hire _____ Last Day Worked _____ ( ) Full-Time ( ) Part-Time
Number of Hours Per Week _____ Rate _____ Paid by ( ) Hour ( ) Day ( ) Week ( ) Month
Housing, Transportation, or Utility Allowance _____ Other Discounts or Allowances _____

	Pay Period			Amount Paid Excluding Overtime or Extra Work	Overtime or Extra Work	GROSS Amount Paid Employee for Each Period		Pay Period			Amount Paid Excluding Overtime or Extra Work	Overtime or Extra Work	GROSS Amount Paid Employee for Each Period
	From	To	Year					From	To	Year			
1							27						
2							28						
3							29						
4							30						
5							31						
6							32						
7							33						
8							34						
9							35						
10							36						
11							37						
12							38						
13							39						
14							40						
15							41						
16							42						
17							43						
18							44						
19							45						
20							46						
21							47						
22							48						
23							49						
24							50						
25							51						
26							52						
	Total							Total					

I hereby certify that the above is a true and correct account, as taken from our payroll records, of the wages paid to the above-named claimant for the periods indicated.

For your protection, New Mexico requires the following wording to appear on this form:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Name of Employer **Signature of Employer** **Position** **Date**

Church Mutual INSURANCE COMPANY, S.I.