



Similar Employee Wage Letter

Policy #:
 Employer:
 Claim #:
 Injured Worker Name:
 Date of Injury:

In order to establish an accurate temporary disability benefit rate for the above referenced injured worker, it is necessary to obtain additional wage information from you. Because the injured worker's employment prior to the injury was less than 12 weeks, Title 72 of the Idaho Code requires that we obtain employment information for two similar employees during the 13 weeks immediately preceding the industrial injury.

Please list the gross income of two similar employees for the period listed below. Please do not change the dates below.

Similar employee 1:

Name of Employee: _____ through _____

Number of
 Hours worked:
 Date Hired:

Similar employee 2:

Name of Employee: _____ through _____

Number of
 Hours worked:
 Date Hired:

Hourly rate of pay for the injured worker at the time of the injury: \$ _____

If you do not have similar employees for the time period listed above, please provide the contracted hours and pay rate for the injured worker.

Number of hours hired to work per week:
 Rate of pay at time of injury: \$ _____

Employer's Signature:
Date Signed:

Thank you for taking the time to provide us with this information.

Submit by one of these methods:

- Upload completed/signed form to our website at: www.hub.idahosif.org/Document/Upload
- Email as an attachment to: claimsim@idahosif.org
- Mail to: State Insurance Fund; PO Box 83720; Boise, ID 83720-0044