Thirteen Week 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 specific wage information from you regarding the thirteen week periods set out below.

Overtime and premium pay are not considered in calculating this benefit. If this individual did in fact work overtime during any or all of the specified periods, **please include only the amount earned at his/her "straight-time" rate of pay for those hours in your calculations.** Gross earnings are requested.
Please do not change the dates below.

through	$
through	$
through	$
through	$

Date of Hire:

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.idahosif.org/document/upload
- Email as an attachment to: claimsim@idahosif.org
- Mail to: State Insurance Fund; PO Box 83720; Boise, ID 83720-0044