

Please complete this form clearly and in BLOCK CAPITALS. Please use a separate sheet of paper if there is insufficient space on this form



Return of Wages Form

Our Claim Ref

Insured:

Name of Employer	
Address	
Post Code	

Employees Name		Clock No	
NI No			

Dates

Accident			
Absence Commenced		Return to work	

Payments Made:

13 weeks prior to absence

Week ending	Hours Worked	Gross Wages inc Overtime	Income tax	NI Contributions	Net Pay
Totals					

Are these details seasonal		Normal	
----------------------------	--	--------	--

During absence from work

Week ending	Wages if any inc. Holiday Pay	Statutory Sick Pay	Non-contributory Sick Pay	Income Tax Payments/ Refunds	NI Contributions	Net Pay
Totals						

Please give details of any wages increases since absence commenced

Signature on behalf of employer	
Position	
Date	