FRINGE BENEFIT INFORMATION

Insured: _____ Insured #: _____ Date of Injury: _____

Claimant: _____ Claim #: _____

Name of Benefit	Dollar amount paid by employer (Please specify if by hour, week, or month.)	Date no longer in effect
1) Long term disability		
2) Health insurance		
3) Retirement benefits		
4) Dental		
5) Vacation pay		
6) Life insurance		
7) Vision		
8) Uniform		
9) Paid holidays		
10) Pension/401K		
11) Other		

Total: $_____

Date: _____ Signature: _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

mcim