WORKER'S COMPENSATION VERIFICATION

Name and Address of Insurance Company

_____

_____

Date_____

Re:_____

SSN_____

The above referenced person has applied for residency / is a resident at _____

As part of our processing, it is necessary that we obtain verification of his/her benefits.

I hereby authorize and request the following information be released to_____

_____

Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

_____

Apartment Manager Signature

Name of Insurance Company: _____

Please check appropriate items:

1. Permanent Disability ( )
   a. Monthly Benefits: $_____
   b. Lump Sum Settlement: $_____
2. Partial/Permanent Disability ( )
   a. Monthly Benefits: $_____
   b. Lump Sum Settlement: $ _____
3. Temporary Disability ( )
   a. Weekly Benefits: $_____
   b. Number of weeks for which benefit will be paid: _____
   c. Lump Sum Settlement: $_____

_____ _____

Signature of Official Date

_____ _____

Title of Official Telephone

WARNING: Section 1001 of Title 18 of U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.