Form Instructions

Please complete as much information as you have available. If you need help completing the form, contact Claims at (208) 332-2100 or (800) 334-2370.

Please save a copy for your records.

Submission options:

- **Upload** at https://hub.idahosif.org/Document/Upload
- **Email** as an attachment to: ClaimsIM@IdahoSIF.org
- **Mail to:**
  SIF, Idaho Workers' Compensation
  P.O. Box 83720
  Boise, ID 83720-0044

Note: Mistakes happen, if you spot or realize an error, please contact us and we will work with you to sort things out. Please be aware that any person who knowingly, and with intent to defraud or deceive any insurance company, submits a statement or claim containing any false, incomplete, or misleading information is violating the law.

Thirteen Week Wage Form

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

Wage Information Required

We require specific wage information from you in order to establish an accurate temporary disability benefit rate for the injured worker.

Premium pay is NOT considered when calculating this benefit. **Overtime hours should be calculated at their "straight time" rate of pay for the following periods.**

Please provide **gross wages**, complete and submit as soon as possible. Do not change the dates below.

through	$
through	$
through	$
through	$

Date of hire:

Employer's signature: Date

Thank you for your cooperation.