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.

Similar Employee 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. Because the injured worker's employment prior to the injury was less than 12 weeks, we are required to obtain employment information for 2 similar employees.

Please complete (do not change the dates below) and submit as soon as possible.

Similar Employee 1

xx/xx/xxxx through xx/xx/xxxx, number of hours worked: _____

Name of employee: _____ Date hired: _____

Similar Employee 2

xx/xx/xxxx through xx/xx/xxxx , number of hours worked: _____

Name of employee: _____ Date hired: _____

Hourly rate of pay for the injured worker at the time of the injury: $_____

I**f you do not have similar employees for the time period listed above,** please provide the contracted hours and pay rate for the injured worker.

Number of hours hired to work per week:

Rate of pay at time of injury: $

Employer's signature: _____ Date: _____

Thank you for your cooperation.