CERTIFICATE FOR THE SETTLEMENT OF LOSS OF INCOME RESULTING FROM VEHICLE ACCIDENT

Case number: _____

To be completed by social security agency

Name of injured: _____	
Date of birth: _____	Tax number: _____
Address: _____	
Occupation: _____	
Employer's name: _____	
Employer's address: _____	
Date of accident: _____	Code number of illness: _____
Because of the above accident the said person was paid: from _____ day _____ month _____ year until _____ day _____ month _____ year _____ Ft, i.e. _____ forints of sickness benefit, sick-leave.	
Dated: _____ , _____ day _____ month _____ year	

_____

signature of body ordering payment of sickness benefit

To be completed by employer.

We confirm that our employee's earnings in the last 12 months preceding the above accident were as follows:

Year	Month	Basic salary	Other wage-like payments (bonus, reward, etc.)	Number of days on sick-leave	Code number of illness	Number of unsalaried days	Deductions imposed on earnings (social security, taxes, contributions to pension fund)
Total							

Dated: _____ , _____ day _____ month _____ year

Accurate completion of this certificate forms the basis of calculating loss of income. Please complete the form with due care.
Please underline the right answer for questions marked in *. Thank you.

Place of seal

_____

signature of employer (mayor's office)