NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF SELF-EMPLOYMENT INCOME

Name and Address of Insurer or Self-Insurer	Name, Address & Phone Number of Insurer's Claims Representative
Government Employees Companies 750 Woodbury Road Woodbury, New York 11797	GEICO P. O. Box 9507 Fredericksburg, VA 22403-9526 516-496-5000

Date	Policyholder	Policy No.	Date of Accident	Claim Number
12/16/25	Dongsheng Xia	4310556974	12/8/25	0476043860000003

NAME AND ADDRESS OF APPLICANT

Dongsheng Danny Xia
2 Eldorado Blvd
Plainview, NY 11803

Dear Applicant:

The information requested below would be used to determine the amount of loss of earnings from work, if any, to which you may be entitled as a result of this accident. Therefore, it would be in your best interest to complete the form and submit all documents requested to the best of your ability. **Kindly note, depending upon the applicable endorsement in effect at the time of the accident, this completed form must be submitted to the insurer as soon as reasonably practicable or no later than 90 days after the work loss was first incurred. If you are unsure of the applicable time requirement, you can contact the claim representative to determine which timeframe is applicable to this claim.**

1. Occupation Rideshare Driver (Uber)
2. Business address N/A
3. Business phone 917-808-5600
4. Nature of business or profession Passenger Transportation
5. Dates you were unable to attend to your business or profession due to this accident:
   From: 12/8/25 Through: present
6. Did you hire anyone to substitute for you while you were absent due to your injuries?
   ☐ Yes ☑ No If "Yes", please complete the following:
   a. Wage or salary paid: $ _____ Daily $ _____ Weekly $ _____ Monthly
   b. Period substitute employed: From _____ Through _____
   c. Gross amount paid to substitute: $_____
   d. Name, address and phone number of substitute: _____
7. If answer to question 6. was "Yes", did you suffer a net loss of earnings from work in addition to the cost of substitute services?
   ☐ Yes ☐ No If "Yes", the amount of net loss claimed: $_____ for the period claimed in question 5.
8. If answer to question 6. was "No", did you suffer a net loss of earnings from work during your claimed disability?
   ☐ Yes ☑ No If "Yes", the amount of net loss claimed:
   $_____ for the period claimed in question 5.
9. In order for us to evaluate your claim, it is essential that you submit copies of your Federal Income Tax returns for the last two years. In addition, submit whatever documents are available to prove your income for the current year. If you have not filed either of the tax returns, submit whatever proof of earnings you have for those years that you feel will assist us in evaluating your claim.

   If we are unable to verify your loss of earnings from the documents submitted, the following additional documentation may be requested.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

Signature of Applicant

12/16/25
Date