

EMPLOYER'S CONFIRMATION OF INCOME & BENEFITS

To be completed by adjuster

Employee's Name		Birth Date (ddmmyyyy)	
Employee Number	Accident Date (ddmmyyyy)	Accident Location	
Claim Number	Adjuster's Name	Phone Number	

To be completed by employer for above named employee

Employment Type (Check One)	Full <input type="checkbox"/>	Part <input type="checkbox"/>	Contractor <input type="checkbox"/>	Seasonal <input type="checkbox"/>	Job Title	
Description of Duties/Responsibilities						
Employment Start Date (ddmmyyyy)	Employment End Date (mmdyyy)		Earnings \$ _____ per _____		Hrs/Wk	
Gross Earnings 12 Months Prior to Accident \$ _____			Number of Weeks Worked in 12 Months Prior to Accident \$ _____			
Time Off Work As Result of Accident	FROM (ddmmyyyy)	TO (ddmmyyyy)	OR	Still Off Work <input type="checkbox"/>		
Working Days Off Due To Accident _____	Gross Pay Lost To Date Due To Accident \$ _____		Overtime Pay Lost Due To Accident \$ _____		Overtime Rate	
Deductions From Gross Pay	Income Tax \$ _____	EI \$ _____	CPP \$ _____	Other Pension \$ _____	Medical Dental \$ _____	
Injuries Sustained In Course Of Employment <input type="checkbox"/> No <input type="checkbox"/> Yes	Benefit Plan Entitlement	WCB <input type="checkbox"/>	EI <input type="checkbox"/>	Short-Term Disability <input type="checkbox"/>	Long-Term Disability <input type="checkbox"/>	None <input type="checkbox"/>
Benefit Plan Name					Est. Weekly Plan Benefit \$ _____	
Benefit Plan Name				Benefit Plan Policy No.		

Does your company have a return to work program?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Contact:
Copy of employee's most recent wage statement?	Yes <input type="checkbox"/>	Not Available <input type="checkbox"/>	

Date	Completed By (Please Print)	Title
	Signature	Phone #