

EMPLOYER'S CONFIRMATION OF INCOME & BENEFITS

TO	Employer
	<p>Your employee has authorized us, by the attached, to obtain details of his/her pay and benefits in order that we may determine the amount of disability payments.</p> <p>Your co-operation in completing and returning this form will be appreciated.</p>

CLAIMANT	Employee	Claim No./Policy No.	
OCCUPATION			
PHYSICAL REQUIREMENTS OF JOB	☐ Sedentary ☐ Heavy Manual ☐ Light Manual	Accident Date	
IF ON SALARY	Rate (Gross) \$	☐ Per week ☐ Per month ☐ Per year	
IF ON HOURLY RATE	Basic hours worked per week \$	Basic Rate per hour (Gross) \$	Cost of Living Bonus (Gross) \$
	Shift Bonus paid in last three months preceding accident \$	Overtime paid in last three months preceding accident \$	
Last Day Worked	Date salary or wages ceased	Length of time employed	
INCOME REPLACEMENT PAID WHILE OFF WORK	Amount \$	per week/month	
	By whom paid?	Length of time payable	
WORKERS' COMPENSATION	Is this employee eligible for Workers' Compensation as a result of the accident? ☐ Yes ☐ No		
MEDICAL EXPENSE RECOVERY PLAN IN FORCE	☐ Yes ☐ No	If "yes" with what company?	
If returned to work, give date:			
Date	Signature	Title	