EMPLOYER'S CONFIRMATION OF INCOME & BENEFITS

TO	Employer
	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. Your co-operation in completing and returning this form will be appreciated.

CLAIMANT	Employee		Claim No./Policy No.
OCCUPATION			
PHYSICAL REQUIREMENTS OF JOB	☐ Sedentary		Accident Date
IF ON SALARY	Rate (Gross) $		☐ Per week ☐ Per month ☐
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