

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	<input type="checkbox"/> Sedentary	Accident Date
IF ON SALARY	Rate (Gross) \$	<input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/>
IF ON HOURLY RATE	Basic hours worked per week \$	Basic Rate per hour (Gross) \$
	Shift Bonus paid in last three months preceding accident \$	Cost of Living Bonus (Gross) \$
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICAL EXPENSE RECOVERY PLAN IN FORCE	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes" with what company?
If returned to work, give date:		

Date	Signature	Title
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