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	☐Heavy Manual ☐Light Manual ☐Sedentary		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 wk./mon.
	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**
_____	_____	_____