MANITOBA PUBLIC INSURANCE

# EMPLOYER'S VERIFICATION OF EARNINGS

PLEASE COMPLETE ENTIRE FORM

CLAIM NUMBER _____

CASE MANAGER _____

## 1) IDENTITY OF EMPLOYEE

| SURNAME | GIVEN NAME | SOCIAL INSURANCE NUMBER |
|---|---|---|
| ADDRESS (NUMBER, STREET, APT. NO.) | | DATE OF BIRTH |
| CITY (TOWN) | POSTAL CODE | DATE OF ACCIDENT |

## 2) AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

I AUTHORIZE PERSONS IN POSSESSION OF ANY INFORMATION CONCERNING MY EMPLOYMENT WHICH MANITOBA PUBLIC INSURANCE DEEMS RELEVANT TO THIS CLAIM TO RELEASE THE INFORMATION TO MANITOBA PUBLIC INSURANCE UPON REQUEST.

DATE_____ SIGNATURE_____

## 3) EMPLOYER IDENTIFICATION (ALL INFORMATION BELOW MUST BE COMPLETED BY EMPLOYER)

| NAME OF BUSINESS | EMPLOYER'S TELEPHONE | NAME OF SUPERVISOR |
|---|---|---|

| ADDRESS (NUMBER, STREET) | DATE EMPLOYMENT BEGAN |
|---|---|
| CITY (TOWN) POSTAL CODE | PROJECTED END OF EMPLOYMENT, IF SEASONAL OR TERM |
| EMPLOYEE'S PROFESSION, TRADE OR JOB | DATE WORK ENDED AS A RESULT OF THE ACCIDENT |
| SUMMARY OF JOB DESCRIPTION (IF WRITTEN DESC. EXISTS, ATTACH COPY) | DATE OF RESUMPTION OF WORK – ACTUAL/PLANNED |

## 4) EMPLOYEE'S STATUS (AT THE DATE OF ACCIDENT)

☐ FIXED HOURS

_____Hours per week

$_____Rate per hour

or, if employee is paid on a salary basis:

$_____Salary per _____ (period)

Gross wages paid in the past 52 weeks

$_____

☐ VARIABLE HOURS

_____Hours per week

$_____Rate per hour

or, if employee is paid on a salary basis:

$_____Salary per _____ (period)

Gross wages paid in the past 52 weeks

$_____

☐ CASUAL

_____Hours per week

$_____Rate per hour

or, if employee is paid on a salary basis:

$_____Salary per _____ (period)

Gross wages paid in the past 52 weeks

$_____

☐ SELF-EMPLOYED

Claimant is:
- ☐ Owner/Operator or Courier
- ☐ Subcontractor
- ☐ Self-Emp. Commission Earner

☐ PIECEWORK

_____Typical weekly average hrs.

_____Average hourly rate

Gross wages paid in the past 52 weeks

$_____

**Were employee's hours scheduled to increase after the date of the accident** ☐ YES _____hours per week, commencing_____ ☐ NO INCREASE SCHEDULED

**EMPLOYEE PAY CYCLE:** ☐ **WEEKLY** ☐ **BI-WEEKLY** ☐ **SEMI-MONTHLY** ☐ **MONTHLY** ☐ **ANNUALLY**

## 5) OTHER REMUNERATION/BENEFITS COMPLETE ONLY IF THE FOLLOWING WILL BE LOST BECAUSE OF ABSENCE DUE TO THE ACCIDENT

| REMUNERATIONS TYPE | PERIOD PRIOR TO ACCIDENT DATE | ACTUAL $ | | | EMPLOYER'S CONTRIBUTION TO BENEFITS PACKAGE | |
|---|---|---|---|---|---|---|
| BONUSES | 52 WEEKS | | VACATION PAY | _____% VACATION PAY | | |
| | | | | PAID OUT ☐ | BENEFIT TYPE | ANNUAL EMPLOYER CONTRIBUTION |
| OVERTIME | 52 WEEKS | | | ACCRUED FOR TIME OFF ☐ | HEALTH | |
| SHIFT PREMIUM | 52 WEEKS | | TIPS REPORTED ON T4? | YES ☐ | DENTAL | |
| PERSONAL USE EMPLOYER'S AUTO | PRIOR CALENDAR YEAR | | | NO ☐ | LIFE INS. | |
| COMMISSIONS | 52 WEEKS | | OTHER CASH BENEFITS | | PENSION | |
| | PRIOR CALENDAR YEAR | | | | OTHER | |
| | AVERAGE OF PRIOR 3 CALENDAR YEARS | | | | | |

**DECLARATION OF EMPLOYER**

I certify that the above information is true and complete. I authorize Manitoba Public Insurance to inspect any records, books, or other documents pertaining to the above named employee, and I will permit access to same upon request.

| SIGNATURE OF EMPLOYER | PRINT GIVEN NAME & SURNAME | POSITION | TELEPHONE NO. | DATE |
|---|---|---|---|---|
| | | | | |

QUESTIONS REGARDING THE COMPLETION OF THIS FORM SHOULD BE DIRECTED TO THE IRI CALCULATION UNIT AT 204-985-3555. OUTSIDE WINNIPEG CALL TOLL-FREE AT 1-800-646-0561. RETURN FORM TO: IRI CALCULATION UNIT, BOX 6300, 234 DONALD STREET, WINNIPEG, MB R3C 4A4 OR FAX TO 204-985-1677