

Employer's Verification of Earnings

Case Manager:	
Claim Number:	

PLEASE COMPLETE ENTIRE FORM

1) Identity of Employee

Legal surname:	Date of birth (dd/mm/yyyy):
Legal given name(s):	Date of accident (dd/mm/yyyy):

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.

Signature:	Date (dd/mm/yyyy):
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3) Employer identification *(all information below must be completed by employer)*

Name of business:		
Name of Supervisor:	Employer's telephone:	
Address (Number, Street):		
City/Town:	Postal code:	
Employee's profession, trade or job:		
Summary of job description (If a written description exists, attach a copy):		Date employment began (dd/mm/yyyy):
Projected end of employment, if seasonal or term (dd/mm/yyyy):	Date work ended as a result of the accident (dd/mm/yyyy):	Date of resumption of work - actual or planned (dd/mm/yyyy):

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**

4) Employee's status (at the date of the accident)

<input type="checkbox"/> Fixed hours	Hours per week:	Rate per hour:
	<i>or, if employee is paid on a salary basis:</i>	\$ _____ Salary per: _____ (period)
	Gross wages paid in the past 52 weeks: \$ _____	
<input type="checkbox"/> Variable hours	Typical weekly average hours:	Average hourly rate: \$ _____
<input type="checkbox"/> Casual	Gross wages paid in the past 52 weeks: \$ _____	
<input type="checkbox"/> Piecework	Gross wages paid in the past 52 weeks: \$ _____	
<input type="checkbox"/> Self-employed		
Claimant is: <input type="checkbox"/> Owner/Operator or Courier <input type="checkbox"/> Subcontractor <input type="checkbox"/> Self-employed Commission Earner		
Were employee's hours scheduled to increase after the date of the accident?		
<input type="checkbox"/> Yes: _____ hours per week, commencing (dd/mm/yyyy):		<input type="checkbox"/> No increase scheduled
Employee pay cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		
Income tax status: <input type="checkbox"/> Tax-exempt <input type="checkbox"/> Taxable		

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 \$:	Vacation pay	Employer's contribution to benefits package	
				Type	Annual Employer Contribution:
Bonuses	52 weeks		<input type="checkbox"/> Accrued for time off <input type="checkbox"/> Paid out % Vacation pay: _____	Health	
Overtime	52 weeks			Dental	
Shift premium	52 weeks			Life Ins.	
Personal use - employer's auto	Prior calendar year		Tips reported on T4? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension	
Commissions	52 weeks		Other Cash Benefits:	Other	
	Prior calendar year				
	Average of prior 3 calendar years				

Declaration of Employer

 The claimant is a relative of the owner of the company/business: Yes No

(If yes, please explain the nature of the relationship):

 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.

Given name & Surname (print):	Position:	Telephone No:
Signature of employer:		Date (dd/mm/yyyy):