MANITOBA
PUBLIC INSURANCE

AUTHORIZATION FOR THE RELEASE OF EMPLOYMENT INFORMATION

Claim Number: _____

TO:_____

I, _____, (customers name), born on _____ (date of birth) was injured in an automobile accident on _____ (date of accident) and I have made a claim to Manitoba Public Insurance (MPI) for benefits under Part 2 of *The Manitoba Public Insurance Corporation Act* (the Act).

Section 142 of the Act requires me to provide MPI with the personal information and the personal health information it deems necessary to determine my eligibility for benefits, and to provide MPI with any authorizations it deems necessary to obtain the information. I am aware that my benefits may be reduced, refused, suspended, or terminated pursuant to Section 160(b) of the Act if I do not comply with Section 142.

I authorize you to provide MPI with such information as it might request regarding my employment, including my job description/essential duties, hours of work, rate of pay, and details of any employment benefits that accrue to me by reason of my employment.

I authorize MPI to collect this information for the purpose of determining my entitlement to Income Replacement Indemnity benefits under Part 2 of the Act. This authorization, or a photocopy of same, shall be your full and sufficient authority to disclose this information to MPI.

This authorization shall be valid for a period of two years from the date of signature, unless earlier revoked, or changed by me, in writing.

_____ _____
Signature of Customer Date (dd/mm/yy)

_____ _____
Witness (anyone 18 years of age or older) Date (dd/mm/yy)

Please return the completed form to:

Manitoba Public Insurance
Injury Claims Management
P.O. Box 6300, Winnipeg, MB R3C 4A4
Or Fax to Number: 204-954-5332