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	☐ VARIABLE HOURS	☐ CASUAL	☐ SELF-EMPLOYED
_____Hours per week	_____Hours per week	_____Hours per week	Claimant is: ☐ Owner/Operator or Courier ☐ Subcontractor ☐ Self-Emp. Commission Earner
$_____Rate per hour	$_____Rate per hour	$_____Rate per hour	☐ PIECEWORK
or, if employee is paid on a salary basis:	or, if employee is paid on a salary basis:	or, if employee is paid on a salary basis:	_____Typical weekly average hrs.
$_____Salary per _____ (period)	$_____Salary per _____ (period)	$_____Salary per _____ (period)	_____Average hourly rate
Gross wages paid in the past 52 weeks	Gross wages paid in the past 52 weeks	Gross wages paid in the past 52 weeks	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 $
BONUSES	52 WEEKS	
OVERTIME	52 WEEKS	
SHIFT PREMIUM	52 WEEKS	
PERSONAL USE EMPLOYER'S AUTO	PRIOR CALENDAR YEAR	
COMMISSIONS	52 WEEKS	
	PRIOR CALENDAR YEAR	
	AVERAGE OF PRIOR 3 CALENDAR YEARS	

VACATION PAY	_____% VACATION PAY	**EMPLOYER'S CONTRIBUTION TO BENEFITS PACKAGE**	
	PAID OUT ☐	**BENEFIT TYPE**	**ANNUAL EMPLOYER CONTRIBUTION**
	ACCRUED FOR TIME OFF ☐	**HEALTH**	
TIPS REPORTED ON T4?	YES ☐	**DENTAL**	
	NO ☐	**LIFE INS.**	
OTHER CASH BENEFITS		**PENSION**	
		OTHER	

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 #, FAX # & EMAIL ADDRESS	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