


**Manitoba  
Public Insurance**
**EMPLOYER'S VERIFICATION  
OF EARNINGS**

PLEASE COMPLETE ENTIRE FORM

CLAIM NUMBER \_\_\_\_\_

CASE MANAGER \_\_\_\_\_

**1) IDENTITY OF THE 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 THE MANITOBA PUBLIC INSURANCE DEEMS RELEVANT TO THIS CLAIM TO RELEASE SAME 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 (INFORMATION BASED ON EMPLOYEE'S STATUS AT THE DATE OF ACCIDENT)**

<input type="checkbox"/> <b>FIXED HOURS</b> _____ Hours per week \$ _____ Rate per hour or, if employee is paid on a salary basis: \$ _____ Salary per _____ (Period) Wages paid in the past 52 weeks \$ _____	<input type="checkbox"/> <b>VARIABLE HOURS</b> _____ Hours per week \$ _____ Rate per hour or, if employee is paid on a salary basis: \$ _____ Salary per _____ (Period) Wages paid in the past 52 weeks \$ _____	<input type="checkbox"/> <b>CASUAL</b> _____ Hours per week \$ _____ Rate per hour or, if employee is paid on a salary basis: \$ _____ Salary per _____ (Period) Wages paid in the past 52 weeks \$ _____	<input type="checkbox"/> <b>SELF-EMPLOYED</b> Claimant is: <input type="checkbox"/> Owner/Operator or Courier <input type="checkbox"/> Subcontractor <input type="checkbox"/> Self-Emp. Commission Eamer <input type="checkbox"/> <b>PIECEWORK</b> _____ Typical weekly average hrs. _____ Average hourly rate Wages paid in the past 52 weeks \$ _____
Were employee's hours scheduled to increase after the date of the accident <input type="checkbox"/> YES _____ hrs. per week, commencing _____ <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			

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

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

**DECLARATION OF EMPLOYER**

I certify that the above information is true and complete. I authorize The Manitoba Public Insurance Corporation 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 SURNAME & GIVEN NAME	POSITION	TELEPHONE NO.	DATE
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QUESTIONS REGARDING THE COMPLETION OF THIS FORM SHOULD BE DIRECTED TO THE IRI CALCULATION UNIT AT 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 985-1677



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 NO INCREASE SCHEDULED

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

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