Return this form to:

Employer's Confirmation Form (OCF-2)

Use this form for accidents that occur on or after November 1, 1996.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

If your insurance company asks you to complete this form, fill in parts 1 through 3 and give the form to your employer or former employer(s) to complete the rest. Please have each employer you listed on your **Application for Accident Benefits** form fill out a separate form. Extra forms are available from your insurance company. Your employer(s) will return the form(s) directly to the insurance company. **Please print clearly.**

Part 1 Applicant Information

Last Name	First Name and Initial	Gender ☐ Male ☐ Female
Address		
City	Province	Postal Code
Birth Date (YYYYMMDD)	Home Telephone	Work Telephone

Name of Insurance Company		
Address		
City	Province	Postal Code
Name of Policyholder		Policy Number

Part 2 Authorization

I authorize my employer to disclose to my insurance company or its authorized representative, any relevant information about my employment, including copies of relevant documents directly relating to my application for income replacement benefits and details of any collateral sources of income or benefits.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision maker	Date (YYYYMMDD)

Part 3 What Salary Information is Needed

Employed

To my employer or former employer:
I was involved in an automobile accident on:

(YYYYMMDD)

To process my application, my insurance company needs information about my salary for the following period before the date of the accident. (If you check ☑ both, the insurance company will determine which period provides the highest benefit.)

4 weeks ☐

52 weeks ☐

Self-Employed

If you are or were self-employed at any time during the four weeks before the accident, please consider yourself the employer for the purpose of completing this form.

I was self-employed four weeks before the accident and I designate the following time period to be used to calculate my income (check one ☑ and proceed to part 4).

☐ 52 weeks

☐ Last complete fiscal year

From (YYYYMMDD)

To (YYYYMMDD)

The rest of this form must be completed by your employer or former employer.

Part 4 Applicant's Income

☐ additional sheets attached

What was the applicant's actual gross income for the period before the accident date checked ☑ above? If the employee worked only part of the period, list the gross income received from you during the period.

	Gross Income Last 4 Weeks Before Accident				Gross Income for Last 52 Weeks Before Accident		Self-Employed: Gross Income
	Week 1	Week 2	Week 3	Week 4	No. of Weeks Worked	Gross Income	
Salary							
Tips, Commissions							
Other Monetary Compensation							
Total							

Was the applicant absent from work for any time during the period checked (☑) in Part 3?

☐ Yes (Give details below) ☐ No

Are there any other types of compensation available from the employer?

☐ Yes (Give details below) ☐ No

Part 5 Other Benefits

To your knowledge, is the applicant eligible to receive the following benefits?

Income Continuation Benefit (short-term or long-term disability plan)	No ☐	Yes ☐	Insurance Company	Policy No.	
Supplementary Medical, Rehabilitation or Attendant Care Benefits	No ☐	Yes ☐	Insurance Company	Policy No.	
Sick Leave	No ☐	Yes ☐	Did applicant use sick credits following the auto accident?	No ☐	Yes ☐

Is the applicant a member of a union?	No ☐	Yes ☐
Does or did the applicant contribute to the Canada Pension Plan or a similar plan?	No ☐	Yes ☐
Was a claim filed with the Workplace Safety and Insurance Board as a result of this accident?	No ☐	Yes ☐

Part 6 Employment Details

☐ additional sheets attached

Date of Employment From (YYYYMMDD) To (YYYYMMDD)	Latest Job Title
Last Date Worked: (YYYYMMDD)	Date of Return to Work (if applicable) (YYYYMMDD)
Brief Job Description	
Essential Tasks of Job (Attach physical demand analysis if available):	
Type of Employment Full-Time ☐ Part-Time ☐ Casual ☐ Seasonal ☐	

Part 7 Employer Information

Company Name		Contact Person
Address		Tax Reg. # or Business Identification Number (BIN)
City	Province	Postal Code
Telephone Number		Fax Number

Part 8 Signature

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

I UNDERSTAND THAT IT IS AN OFFENCE UNDER THE INSURANCE ACT to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. Regulated sectors may be subject to an examination or inquiry about matters in connection with a licence and or unfair or deceptive act or practice. Non-compliance with applicable regulations may result in enforcement actions ranging from an administrative monetary penalty to prosecution under the Provincial Offences Act.

I FURTHER UNDERSTAND THAT IT IS AN OFFENCE UNDER THE FEDERAL CRIMINAL CODE for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and **PREVENTING, DETECTING AND SUPPRESSING FRAUD.**

Signature of Employer:	Date (YYYYMMDD)

Employer Name: (Please print)	Title