

Return this form to:

# Employer's Confirmation Form (OCF-2)

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

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address							
City			Province			Postal Code	
Birth Date	year	month	day	Home Telephone	Area Code	Work Telephone	Area Code
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)
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## Part 3 What Salary Information is Needed

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

year	month	day

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 

year	month	day

To 

year	month	day

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

## Part 4 Applicant's Income

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 Weekly 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	
<b>Salary</b>							
<b>Tips, Commissions</b>							
<b>Other Monetary Compensation</b>							
<b>Total</b>							

**Part 4  
Applicant's  
Income  
(cont'd)**

additional sheets attached

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

Yes (Give details below)     No

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

Yes (Give details below)     No

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**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 <input type="checkbox"/>	Yes <input type="checkbox"/>	Insurance Company	Policy No.
Supplementary Medical, Rehabilitation or Attendant Care Benefits	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Insurance Company	Policy No.
Sick Leave	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Did applicant use sick credits following the auto accident?	No <input type="checkbox"/> Yes <input type="checkbox"/>

Is the applicant a member of a union?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Does or did the applicant contribute to the Canada Pension Plan or a similar plan?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Was a claim filed with the Workplace Safety and Insurance Board as a result of this accident?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

**Part 6  
Employment  
Details**

additional sheets attached

Date of Employment	year	month	day	year	month	day	Latest Job Title
From:				To:			
Last Date Worked:	year	month	day	Date of Return to Work (if applicable)			year    month    day
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	Area Code                      FAX Number                      Area Code

**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. 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.

Signature of Employer:
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Date:	year	month	day

Employer Name: (Please print)	Title:
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