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: 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)

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	
Salary							
Tips, Commissions							
Other Monetary Compensation							
Total							

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

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: year month day To: year month day		Latest Job Title
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:	Date: year month day

Employer Name: (Please print)	Title: