Certificate of Earnings

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

CLAIM NUMBER	ADJUSTER NAME	ADJUSTER NUMBER	TELEPHONE NUMBER	TOLL FREE NUMBER

EMPLOYEE NUMBER	EMPLOYEE NAME	DATE OF BIRTH (ddmmmyyyy)

To be completed by employer for above named employee

EMPLOYMENT TYPE (check one only)
☐ F/T ☐ P/T ☐ Contractor ☐ Seasonal worker ☐ Casual

JOB TITLE

DESCRIPTION OF DUTIES / RESPONSIBILITIES (please attach copy of job description)

EMPLOYMENT START DATE	EMPLOYMENT END DATE / LAST DAY WORKED	EARNINGS	HRS / WK
		$ _____ ☐ HR ☐ MO ☐ WK ☐ YR	

Gross Earnings (including Vacation Pay) between _____ and _____ : $ _____

Number of weeks worked in above noted period (including Paid Vacation): _____

TIME OFF WORK AS RESULT OF ACCIDENT
from _____ to _____ ☐ Still off work

INJURIES SUSTAINED IN COURSE OF EMPLOYMENT
☐ Yes ☐ No

WORKING DAYS OFF DUE TO ACCIDENT	GROSS PAY LOST TO DATE DUE TO ACCIDENT	OVERTIME PAY LOST DUE TO ACCIDENT	OVERTIME RATE
	$	$	$

DEDUCTIONS FROM GROSS PAY	INCOME TAX	EI	CPP	OTHER PENSION	MEDICAL DENTAL
	$	$	$	$	$

BENEFIT PLAN ENTITLEMENT

		DURATION	AMOUNT
☐ WorkSafe BC	☐ Pay Sick Leave	_____	$ _____
☐ EI	☐ Short Term Disability	_____	$ _____
☐ None	☐ Long Term Disability	_____	$ _____

☐ Extended Health Benefits (If yes, please provide details of coverage available below or attach copy of the plan coverage)

_____

_____

BENEFIT PLAN NAME	BENEFIT PLAN POLICY NUMBER	BENEFIT CONTACT NAME	CONTACT PHONE NUMBER

Does your company have a return to work program? ☐ Yes ☐ No Contact:

Copy of employee's most recent wage statement? ☐ Yes ☐ Not Available

Certification

Please read carefully before signing.

The above information is provided to the Insurance Corporation of BC in connection with an insurance claim application and is true and complete. I understand that it is an offence to provide false or misleading information.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act* (BC) and section 29 of the *Insurance (Vehicle) Act* (BC) for the purpose of investigating, managing or settling the claim. Questions about the collection of this information may be directed to the **adjuster**, or call 604-661-2800 or contact the Privacy & FOI Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

EMPLOYER _____ SIGNATURE _____

ADDRESS _____ NAME (please print) _____

_____ POSITION _____

TELEPHONE _____ DATE _____