Detailed Wage Loss

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	DATE OF REHIRED (if applicable)

HRS / WK	REGULAR DAYS OFF	EARNINGS			SHIFT DIFFERENTIALS (if applicable)
		$ _____	☐ HR ☐ WK	☐ MO ☐ 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
	$

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

OVERTIME (O/T) RATE	O/T PAY LOST DUE TO ACCIDENT	AVERAGE O/T HOUR WORKED	O/T HRS TWO MONTHS PRIOR TO ACCIDENT
$	$	per day _____ per week _____	$

WAS THIS OVERTIME EXPECTED TO CONTINUE?	WHAT RATE OF PAY APPLIES TO OVERTIME HRS?
☐ Yes ☐ No	$

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

1. Does your company have a return to work program? ☐ Yes ☐ No

   Contact: _____

2. Are/were there any light duties or part-time work this employee could do to enable an earlier return to regular employment? ☐ Yes ☐ No

   Description: _____

3. Has the employee requested this work? ☐ Yes ☐ No

4. What vacation pay has accrued and how is this affected by the absence?

_____

5. Are there any other employer contributions such as medical plan, pension, etc., that are/were affected by this employee's absence? ☐ Yes ☐ No

   If yes, please describe: _____

6. Have there been any slowdowns, layoffs, or strikes which have affected employment since the date of hire or the date of the accident? ☐ Yes ☐ No

   If yes, please describe: _____

7. Has this employee had any illnesses, accidents, or extended absences since being employed with your company? ☐ Yes ☐ No

   If yes, please describe: _____

8. What was the first full day missed as a result of this accident? _____

9. On what date did the employee return to active employment? _____

10. Are they still actively employed? ☐ Yes ☐ No

11. Please describe how the sick day entitlement accrues or renews. _____

_____

12. How many sick days were available to this employee at the time of the accident? _____

_____

13. How many were used? _____

14. Can the used sick days be reinstated upon reimbursement of the money paid to the employee? ☐ Yes ☐ No

15. Can sick days be "cashed out" at any time by the employee if not used? ☐ Yes ☐ No

_____

16. Please make any additional comments you feel are relevant and not covered in this questionnaire.

_____

_____

_____

_____

17. 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