Authorization to Furnish Employment and Benefits Information

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

Fax 1-877-686-4222

CLAIM NUMBER	ADJUSTER NAME	EMPLOYEE NUMBER	DATE
CLAIMANT NAME			

To whom it may concern:

I, ______________________________ , authorize

- my present and previous employer(s) or their accountant(s) and/or my accountant(s)
- and/or my employer's health care (medical and disability benefits) insurer(s) ______________________________
- and/or my health care (medical and disability benefits) insurer(s) ______________________________
- and/or any family health care (medical and disability benefits) insurer(s) ______________________________
- and/or the provider (including the government of a province or territory of Canada, Canada or another jurisdiction) of benefits or other forms of income assistance under the Employment Insurance Act (Canada) or other applicable laws;
- and/or any other income replacement insurer(s) ______________________________ (INSURANCE COMPANY NAME)
- and/or accident benefit insurer ______________________________ (INSURANCE COMPANY NAME)

to give any representative of the Insurance Corporation of British Columbia (ICBC), in any format specified by ICBC including verbal, written, and electronic formats, all information relating to my salary, wages, commissions, earnings, profits, insurance benefits, health care benefits, income assistance and/or lost time from my employment and/or business arising from an accident that occurred on ____________________ .
DATE

This is not a release of claim for damages.

____
SIGNATURE

____
ADDRESS

____
PHONE NUMBER