DRAFT Employer Statement of Earnings (Form CF-1B)

For accidents that occur on or after January 1, 2027

Part 1- This part to be completed by the Insurance Company		
Insurance Company Name:		
Claim Number:	Date of Accident: DD/MM/YYYY	Policy Number:
Claimant Last Name	First Name	Middle Name
Insurance Case Manager Name:	Email:	Contact Phone Number

This form must be completed by the employer or former employer of a claimant for compensation under the *Automobile Insurance Act* (AIA), at the request of the insurer.

Important Notice Regarding Claimant's Employment Information

Under Section 56 of the AIA, an employer or former employer of a claimant must, whenever an insurer requests, provide the claimant's employment information to the insurer as soon as practicable. Employment information includes a statement of the claimant's earnings while the claimant was employed and any other information that relates to the claimant's employment [prescribed by regulation]. The information requested in this form will be used to determine the claimant's eligibility for compensation and to administer their claim, and will be collected, used, and disclosed in accordance with the AIA and applicable privacy legislation.

If you have questions about, or need help completing this form, contact the insurance case manager, or refer to the Consumer Guide.

The insurance case manager may contact you for clarification or additional records to confirm the information reported on this form.

Part 2- Employment Information			
Employer Name		CRA Business Number (if applicable)	
Mailing Address			
City or Town Choose an item.		Province/ Territory/ State	
Name of Supervisor		Position	
Phone Number		Business Phone Number	
Claimant (Employee) Job Title			
Summary of job description (if written description exists, attach a copy)			
Date Employment Began (if not started, use date scheduled to begin employment) (DD/MM/YYYY)		Date work ended because of the accident (if not working on the date of the accident, indicate last date worked) (DD/MM/YYYY)	
Period off work due to the accident (if applicable)		From: (DD/MM/YYYY) To: (DD/MM/YYYY) ☐Ongoing	

Were injuries sustained in the course of employment? ☐Yes ☐No ☐Unknown

If yes, was a Worker's Compensation Board (WCB) claim filed?
☐Yes, provide the WCB Claim number (if known) and determination:

☐No (explain why a claim was not filed with WCB): _____

Is the employee currently employed, and is a return to work (RTW) being considered at this time?
☐Yes → Complete Parts 3, 4, 5, 5a, 6 and 7
☐No → Complete Parts 3, 4, and 7 but do not complete Parts 5, 5a, and 6 unless requested by the insurance case manager

Part 3- Earning Details	
Employment type ☐Permanent ☐Temporary ☐Seasonal ☐ Contract/Fixed Term	Employment status on the date of the accident: ☐Working ☐On leave ☐Laid off ☐Seasonal off-season ☐ Employment ended ☐Other (provide details)
Hour per week:……	Rate per hour: ……

☐Fixed hours	or, if employee is paid on a salary basis:	$.....Salary per:……..
	Gross wages paid in the past 52 weeks: $.....	
☐Variable hours	Typical weekly average hours: ……..	Average hourly rate:……
☐Casual ☐Piecework	Gross wages paid in the past 52 weeks: $.....	

Deductions from gross pay for pay period	Income Tax	EI	CPP

Were employee's hours or earnings scheduled to increase after the date of the accident?
☐Yes, increasing to _____hr/week commencing (DD/MM/YYYY)
☐Yes, increasing to $_____commencing (DD/MM/YYYY)
☐No scheduled increase

Employee's pay cycle:☐Weekly ☐Bi-weekly ☐Monthly☐Other _____

Complete this section only if, on the date of the accident, the employee was employed on a temporary, seasonal or contract basis, or was on approved leave.

Is the employee expected to be rehired or return to work for a future season or term? ☐Yes ☐No ☐Unable to determine currently

Expected date of rehire or return (if known): (DD/MM/YYYY)

Planned end date of the most recent employment term: (DD/MM/YYYY)

Attach supporting documentation (* case manager may request additional information/ documents)
☐Recent T4 ☐Record of Employment (ROE) ☐Recent Pay Stub ☐Collective agreement ☐Timesheet/ Work schedule ☐Other

Part 4- Other Remuneration/Benefits

Income replacement type	Amount	Frequency	Policy or Plan Name	Contact
Paid Sick Leave	$	☐Per day ☐Per week ☐Other:……..		

Complete this section only if paid sick leave was available to the employee at the time of the accident.

Income replacement type	Policy or Plan Name	Contact
Short Term Disability		
Long Term Disability		

Amounts and payments for Short- Term and Long-Term Disability will be confirmed directly with the plan administrator, if applicable.

Remuneration Type	Period Prior to Accident Date	Actual $			Employer contribution to Benefits Package	
Bonuses	52 weeks		Vacation Pay	____% Vacation Pay	Benefit type	Annual employer contribution
Overtime	52 weeks			☐Paid out ☐Accrued for time off	Extended Health	
Shift Premium	52 weeks		Tips reported on T4	☐Yes ☐No	Dental	
Personal Use Employer Auto	Prior Calendar Year		Other cash benefits (e.g. Profit share)		Life Ins.	
Commissions	☐52 weeks ☐Prior Calendar Year ☐Avg. prior 3 calendar years				Pension Other:	

See Part 2 for instructions on when Parts 5, 5a, and 6 must be completed.

Part 5- Physical Job Demands			Indicate the physical job demands in the table below.
Physical demand	**Required**	**Activity frequency/ duration**	**Comments**
Lifting from floor to waist (specify weight e.g., up to 5 kg, 5-10kg, other)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Lifting from waist to shoulder (specify weight e.g. up to 5kg, 5-10kg)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Standing	☐Yes ☐No	☐<15 min ☐15-30 min ☐>30 min	
Sitting	☐Yes ☐No	☐<30 min ☐30-60 min ☐>60 min	
Walking	☐Yes ☐No	☐Short distances ☐Long distances	
Climbing stairs/ladders	☐Yes ☐No	☐Occasional ☐Frequent	
Bending/twisting repetitive movement: (specify)	☐Yes ☐No	☐Occasional ☐Frequent	
Use of hands (gripping, pinching, fine motor)	☐Yes ☐No	☐Occasional ☐Frequent	
Operating machinery or vehicles	☐Yes ☐No	Type:	
Exposure to vibration/ noise	☐Yes ☐No	☐Whole body ☐Hand/Arm	

Part 5a- Cognitive Job Demands			Indicate the cognitive demands that are essential to the job tasks below (e.g., attention, memory, decision-making). Use Comments to describe safety-critical tasks, pace, and examples.
Cognitive demand	**Required**	**Activity frequency/duration**	**Comments**
Sustained attention / concentration	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Divided attention / multitasking	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Short-term memory (remembering steps, locations, instructions)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Following detailed instructions / procedures	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Problem-solving / troubleshooting	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Judgment / decision-making (including safety decisions)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Pace / time pressure (deadlines, production targets)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Reading / writing / documentation	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Communication demands (verbal, radio/phone, customer/client)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	
Computer/screen use & visual demands (screen time, reading on screen, visual scanning)	☐Yes ☐No	☐Occasional ☐Frequent ☐Constant	

Part 6- Return to work

See Part 2 for instructions on when this part must be completed.

Does your company have a return-to-work program? If yes, provide contact information for the person who is responsible for the program.

Has the employee returned or attempted to return to regular or modified duties or hours?

☐No

☐Yes, start date DD/MM/YYYY to end date (if applicable) DD/MM/YYYY/☐Ongoing

If yes, describe the limitations preventing the employee from continuing

What accommodation or safety measures may be needed to help the employee return to work? ☒Select all that apply and describe below.

- ☐Modified work hours/days
- ☐Modified work location
- ☐Modified job requirements
- ☐Assistive device(s)
- ☐Additional support (e.g. colleagues helping with specific tasks)
- ☐Reduced screen time/visual stimulation (e.g., computer use, bright light)
- ☐None
- ☐Other (specify): _____

If any accommodation has already been tried, explain what was done and the result.

Part 7- Certification and Declaration by Employer Representative

I certify that the information disclosed on this form is true and correct to the best of my knowledge.

I understand that knowingly providing false, misleading, or incomplete information may affect the claimant's entitlement to compensation under the AIA and may result in enforcement action or other consequences under applicable law.

I understand that non-compliance with the AIA or other applicable laws may affect the claimant's entitlement to compensation under the AIA and may result in enforcement action or other consequences under applicable law.

I understand that it is an offence under the *Criminal Code of Canada* for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

I understand that information disclosed on this form or obtained under the authority of section 56 of the AIA, may be collected, used, and disclosed only for purposes authorized under the AIA, its regulations, and applicable privacy legislation. These purposes include determining the claimant's entitlement to compensation and administering the claim, including processing benefit payments, coordinating required assessments, and communicating with relevant parties.

Information may also be used or disclosed, in accordance with applicable law, to comply with legal or regulatory obligations.

(DD/MM/YYYY)

Full Name	**Signature**	**Date**

Forward this form and all attachments to the insurance company