Multi-Sector Pension Plan

105 Commerce Valley Drive West, Suite 310, Thornhill, ON L3T 7W3
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WSIB INFORMATION REQUEST FORM

(TO BE COMPLETED BY THE EMPLOYER)

EMPLOYEE NAME: _____

SIN: _____

DATE OF INJURY: _____

DATE OF RECOVERY: _____

PENSIONABLE EARNINGS FOR THE LAST FOUR WEEKS PRECEDING:

DATE OF INJURY BY WEEK:

WEEK 1 _____

WEEK 2 _____

WEEK 3 _____

WEEK 4 _____

EMPLOYER'S NAME:	
AUTHORIZED SIGNATURE OF EMPLOYER:	
PRINT NAME AND TITLE:	
DATE:	