



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)

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

Personal information obtained with this authorization is collected under section 26 (a) and (c) of the *Freedom of Information and Protection of Privacy Act* (BC) and section 9 of the *Insurance Corporation Act* (BC) for the purpose of investigating, managing or settling your claim. Questions about the collection of this information may be directed to your **adjuster**, or call 604-661-2800 or contact the Privacy & FOI department at 151 W Esplanade, North Vancouver, BC V7M 3H9.