NHRIPP
NURSING HOMES AND RELATED INDUSTRIES PENSION PLAN

WSIB INFORMATION REQUEST FORM

(TO BE COMPLETED BY THE EMPLOYER)

EMPLOYEE INFORMATION

Employee Name	SIN

Date of Injury MM / DD / YYYY	Date of Recovery MM / DD / YYYY

PENSIONABLE EARNINGS

Pensionable earnings for the last four weeks preceding date of injury by week:
(Not required for Maternity/Paternity/parental unless in PEI)

Week 1	Week 2
Week 3	**Week 4**

AUTHORIZATION AND SIGNATURE

Employer's Name: _____

Authorized Signature of Employer: _____

Print Name & Title: _____

Date: _____