Optional Coverage Application Form for Sole Proprietors, Partners in a Partnership, or Non-Incorporated Employers

Name:__________________________ ________________________Employer #: ________________

I understand and acknowledge that in the event of a time-loss claim for a work-related disability, loss of earning benefits will be paid at a rate of 75%[1] of actual proven earnings. Actual proven earnings under the policy will be based on the lesser of the policy coverage amount purchased and in place at the time of the injury or actual proven earnings, up to the Maximum Wage Rate as established by the Yukon Workers' Compensation Health and Safety Board (YWCHSB) for the year of coverage. Other sources of assessable income from concurrent employment will be considered in addition to the Optional Coverage earnings protection.

________________ Please Initial As Confirmation of Having Read the Above Section

- This application form **must** be completed and **signed** by the Employer or their Authorized Agent.
- Coverage will take effect on the date YWCHSB approves the signed application form.
- The amount of coverage applied for in this application is based on an estimate of actual proven earnings, up to the Maximum Wage Rate for the current year.
- In the event of a time-loss claim resulting from a workplace disability, proof of earnings will be provided to the YWCHSB in the form of audited financial statements by a certified accountant, income tax return forms submitted to Canada Revenue Agency, or another form as determined by the YWCHSB.
- Coverage may be purchased for a period of time less than one year and must be renewed annually at the end of each calendar year. If your work is year round, your compensation coverage must be renewed annually for the end of each calendar year.
- The minimum assessment premium for Optional Coverage for each individual, regardless of the period of time that coverage is in place, is $150.00.
- $150.00 is charged for each time a business is opened in a calendar year.

1. Optional coverage for: ________________________________
(Print name)

Requested Coverage Amount: $___________________________(Maximum amount $77,920.00)

Begins: ________________________ Ends:____________________________
Year/Month/Day Year/Month/Day

____
Signature of individual being covered under policy

EMPLOYER'S CERTIFICATION:

I ________________________certify that the information provided on this form is true
(Print Name)
and completed to the best of my knowledge and agree to the terms and conditions of Optional Coverage.

______________________________________ Date _____________________________
Signature – Employer or Authorized Agent

For more information please contact our office on business days between Monday through Friday, 8 am and 5 pm at:

Yukon Workers' Compensation Health and Safety Board
401 Strickland Street
Whitehorse, Yukon Y1A 5N8

Phone: 867-667-5095
Toll Free: 1-800-661-0443
Fax: 867-393-6279
Email: wchsbassessments@gov.yk.ca

[1] Subject to policy EL-02 Minimum Compensation, which will apply a rate of 100% for earnings less than or equal to 25% of the Maximum Wage Rate.

The information collected is under the authority of the *Worker's Compensation* Act for the purposes of administering worker's compensation. It is an offence under the Workers' Compensation Act to provide false or misleading information to the Board.