



Application for Extended Coverage Outside Canada

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Telephone:** (867) 667-5645, **Toll free:** 1-800-661-0443, **Fax:** (867) 393-6279, **Website:** www.wcb.yk.ca

NOTE: Print this application, fill it out and mail or fax it to YWCHSB, or [click here](#) to file an application on-line.

Employer name _____ Employer number _____

Business name _____ Telephone number _____

Employer address _____

Workers working outside of Canada:

1. Name: _____ Is this worker a Yukon resident? Yes No

How long has the above worker been employed by the above stated employer in Yukon? _____

2. Name: _____ Is this worker a Yukon resident? Yes No

How long has the above worker been employed by the above stated employer in Yukon? _____

NOTE: If there are more than two workers who will be working outside of Canada please supply the requested information for each of these workers on a separate sheet and submit it along with this application.

Exact location of work: _____

WCB Representative in Jurisdiction where work will be done: _____

Date of work outside Canada: from _____ to _____
yy/mm/dd yy/mm/dd

Description of work being done: _____

Is the work to be done outside of Canada typical of work normally conducted by this company in Yukon? Yes No

I, _____ do hereby certify that I make this declaration conscientiously believing that the statements and information are true and correct.

Name (please print) _____

Signature _____
Date

A decision on your application will be provided within two to three business days after receiving it. If you have not heard from us at the end of this time period or if you require an immediate response please call YWCHSB at (867) 667-5095 or toll free at 1-800-661-0443.

*Please note pursuant to **Section 7(4)** that: a worker or the worker's dependant must notify the board within 30 days of the date the workers' work-related injury arose of their intention to claim compensation under this section.

Employers are required to report medical or time loss injuries within 3 days of the injury.

INTERNAL USE ONLY: Application: Approved Denied

Director of Assessments _____
Date