Workers' Safety and Compensation Board Yukon

Optional Coverage Application Form - Proprietors - Partners

PRINTED: 23-11-2026

If this application is approved by the board, the following terms and conditions apply:

the amount of coverage purchased must closely reflect your actual employment earnings and is subject to the maximum annual earnings amount for the current year.

in the event of an injury the board may require documentation verifying earnings.

coverage may be purchased for a period of time less than one year but not for a period less than one month (coverage cannot extend past December 31)

coverage is not effective until the application has been approved by the board.

coverage expires December 31 unless an earlier date is requested and must be renewed annually.

the minimum assessment premium is $150.00.

in the event of a work-related injury, an individual covered by optional coverage can submit a claim and may be eligible for compensation benefits. If the claim is accepted, loss of earnings benefits will be calculated in accordance with policy 3.1 Loss of Earnings Benefits.

the board may cancel coverage if the account is not in good standing, false or misleading information has been provided to the board or required information has not been provided to the board

if this application is approved you must complete the application for registration

if this application is not granted you will be advised in writing the reasons for denial

if this application is approved the individual will be deemed to be the worker of the applicant and the applicant will be deemed to be the employer of the individual under the Workers' Safety and Compensation Act

Proprietor Contact Information

*Legal Name

Trade Name

Customer Number

12345-12345 (5 digits all numbers - 5 digits all numbers)

*Street Number

Street Name

*City

*Province/Territory

PRINTED: 23-11-2026

*Postal Code

*Primary Phone (ex: (999) 999-9999) Secondary Phone (ex: (999) 999-9999) *Email Address

Coverage Details

*Coverage Amount

$

Requested coverage amount, not to exceed the maximum annual earnings of $107599 for 2026.

*coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

*coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Signature, consent and declaration

This information is being collected for the purpose of administering and enforcing the Workers' Safety and Compensation Act in compliance with the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, please contact the board's Privacy Officer at 401 Strickland St., Whitehorse, YT, Y1A 5N8 or call 867-667-5645 or 1-800-661-0443.

By submitting this form I declare that the information provided is true and correct. I consent to the release from any third party to the Workers' Safety and Compensation Board (board) of any medical, employment or other information relevant to my claim. I consent to the board disclosing to health care providers, hospitals, physicians, my employers, other workers' compensation boards and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

*Name/signature Date (DD/MM/YYYY)

/ /

My email is (ex: you@wcb.yk.ca)