

PRINTED: 03-10-2026

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

the applicant must be a registered employer under the Workers' Safety and Compensation Act

volunteers: the amount of coverage that must be purchased for each individual is equal to half the maximum annual earnings for the current year (coverage amount cannot exceed this amount)

elected or appointed officials: the amount of coverage must closely reflect the actual employment earnings of the individual and is subject to the maximum annual earnings amount for the current year

coverage may be purchased for a period of time less than one year but not for 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

it is the employer's responsibility to inform the individuals of coverage that has been approved under this application

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

Employer Information

* Legal Name

Trade Name

Customer Number

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

* Street Number

* Province/Territory

* Street Address

* Country

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PO Box

* Postal Code

* City

Email (ex: you@wcb.yk.ca)

* Primary Phone Number (ex: (999) 999-9999)

Secondary Phone Number (ex: (999) 999-9999)

Coverage Details

* I am purchasing coverage for

First Nation Elected or Appointed Officials

Volunteers

How many workers are you applying for

If you have more than 10 people to apply for you will need to start an additional application.

Worker 1

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

Worker 2

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

Worker 3

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First Name of person you are applying for optional coverage

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

* Coverage Amount

\$

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

Worker 4

First Name of person you are applying for optional coverage

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

* Coverage Amount

\$

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

Worker 5

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

* Coverage Amount

\$

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

Worker 6

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

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* Coverage Amount

\$

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

Worker 7

First Name of person you are applying for optional cover

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

Worker 8

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

Worker 9

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

Worker 10

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

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coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

* Coverage Amount

\$

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

How many volunteers are you applying for

If you have more than 10 people to apply for you will need to start an additional application.

Coverage for each volunteer is 1/2 of the maximum annual earnings for the year coverage is purchased.

Volunteer 1

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

Volunteer 2

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

Volunteer 3

First Name of person you are applying for optional coverage for

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.enddate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate.helper

Volunteer 4

First Name of person you are applying for optional coverage for

Name of person you are applying for optional coverage for

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coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 5

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 6

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 7

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 8

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 9

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

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coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

Volunteer 10

First Name of person you are applying for optional coverage for

coverage.enddate (DD/MM/YYYY)

/ /

coverage.enddate.helper

Last Name of person you are applying for optional coverage for

coverage.startdate (DD/MM/YYYY)

/ /

coverage.startdate.helper

coverage.enddate (DD/MM/YYYY)

/ /

*coverage.enddate.helper***Signature, consent, declaration**

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.