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This information is being collected for the purposes of administering and enforcing the Workers' Safety and Compensation Act and is collected under the authority of that Act and the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, please contact the Privacy Officer at WSCB at the above listed address or at (867)667-5645 or 1-800-661-0443.

You only need to complete the Application for Compensation Form if you want to apply for compensation benefits in the Yukon. An application for compensation must be submitted within 12 months of the date of injury or death.

Please allow 30 to 40 minutes to complete this form.

Employer Information

* Business Legal Name

Trade Name or Government Department

What is the name of the business on your paycheck?

* Street Number

* Street Name

* City

* Province/Territory

* Postal Code

* Country

* Is the physical address the same as mailing address?

Yes

No

Mailing Address (character limit: 570)

Only fill out if mailing address is different from address you provided above

* Employer Contact Name

* Employer Contact Phone Number (ex: (999) 999-9999)

Provide the name of the person you want us to contact to discuss your claim

* Employer Contact Title

Supervisor

Manager

HR

Health and Safety Rep

Business Owner

Other

* Employer Contact Email Address (ex: you@wcb.yk.ca)

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Worker Information

* First Name (As shown on valid government-issued ID) Middle Name * Last Name (As shown on valid government-issued ID)

* Gender

Male

Female

Other

* Date of Birth (DD/MM/YYYY)

/ /

* Date of worker's death (DD/MM/YYYY)

/ /

Social Insurance Number

Needs to be 9 digits long (three sets of 3 numbers)

Employment Information

* What was the worker's job at time of the work-related injury?

* Was the worker a partner, owner or proprietor in this business?

Yes

No

What is their job title, what did they do?

Proprietor

Partner

Owner

Work-related injury information

* Describe, based on the information you have, what happened to cause the incident that lead to the fatality? (character limit: 570)

* Was this a motor vehicle accident?

Yes

No

Applicant Information

The information you provide in this section will help us determine eligibility for compensation for a spouse, dependent(s) or the estate of a deceased worker.
Did accident involve a train, plane or automobile?

* What is your relationship to the deceased worker?

Spouse

Dependent

Executor of the Estate of the deceased worker

Other (please call 667-5645 or toll free 1-800-661-0443 and ask to speak with the manager of Claimant Services)

* Do you require an interpreter or translation services?

Yes

No

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If yes, which language?

a "spouse" in respect of a worker means the individual who, at the date of the worker's death, lived with the worker, and
(a) to whom the worker was legally married at the date of the worker's death, or
(b) with whom the worker had lived as a couple for at least 12 months immediately before the worker's death

a "dependent" means a member of the family of a worker who is wholly or partially dependent on the worker's earnings for the ordinary necessities of life or who, but for the worker's work-related injury, would have been so dependent

a "Executor/Administrator" is a person appointed by a will or by the courts to manage an estate. The executor is the personal representative of the estate and is trusted by the creditors and beneficiaries of the estate.

Spouse Information

* First name

* Last name

* Street Number

* Street Name

* City

* Province/Territory

* Postal Code

* Country

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

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

* Please provide your Social Insurance Number

We ask for your SIN number to pay benefits, if you are eligible. Needs to be 9 digits long (three sets of 3 numbers)

* Are you legally married to the worker

* At the date of the death of the worker we were living as a couple for at least 12 months immediately before the worker's death.

Yes

Yes

No

No

* Does the deceased worker have any children?

* Please indicate how many children

Yes

No

If these children are under 19 years of age or still attending school, please list them, their birth dates and whether they live with you and your spouse or with someone else. If you have children aged 19 to 21 years who are still in school,

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First Name	Last Name	Date of Birth (DD/MM/YYYY) / /	Do they reside with you? Yes No
First Name	Last Name	Date of Birth (DD/MM/YYYY) / /	Do they reside with you? Yes No
First Name	Last Name	Date of Birth (DD/MM/YYYY) / /	Do they reside with you? Yes No
First Name	Last Name	Date of Birth (DD/MM/YYYY) / /	Do they reside with you? Yes No
First Name	Last Name	Date of Birth (DD/MM/YYYY) / /	Do they reside with you? Yes No

You may be asked to submit any of the following documents once the claim acceptance has been established.

Marriage certificate

Proof of common law (helper text: evidence that: my common-law partner included me in their benefits with their employer; the Canada Revenue Agency was notified as to our marital status as common law partners; we paid rent together; we paid mortgage payments together; we had a joint bank account; our bills were sent to the same address; our driver's licenses show the same address; our health care cards show the same address; our voter's registrations show the same address; or any other evidence that shows we shared household duties and presented ourselves as a couple who were living together.)

Birth certificates for children

Confirmation of children's enrollment in an educational institution.

Copy of death certificate, if available

Dependent(s) Information

* First Name	* Last Name
Street Number	* Street Name
* City	* Province/Territory
* Postal Code	* Country

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

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

* Social Insurance Number

* Are you in school full time?

Yes

No

We ask for your SIN number to pay benefits, if you are eligible. Needs to be 9 digits long (three sets of 3 numbers)

* Date of Birth (DD/MM/YYYY)

/ /

You may be asked to submit any of the following documents once the claim acceptance has been established.

Proof of enrollment in school, if applicable
Copy of your birth certificate

Executor/Administrator Information

* First name

* Last Name

* Street Number

* Street Name

* City

* Province/Territory

* Postal Code

* Country

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

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

You will be required to provide verification that you are the executor or the administrator of the estate of the deceased worker. Please contact the manager of Claimant Services at 667-5319 to discuss the appropriate documentation.

Signature, consent and declaration

I acknowledge that electronic communication has inherent security risks, as do all forms of communication. Notwithstanding the inherent risks of electronic communication, I consent to the use of electronic methods to transmit and receive information, including confidential and personal information between the board and myself. This consent will remain in effect until written notice to revoke this authorization has been received by the board.

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. I understand that my social insurance number may be used for reporting to Canada Revenue Agency and collecting information from Canada Revenue Agency for the purpose of determining benefit entitlement.