Workers' Safety and Compensation Board Yukon

REQUEST TO REACTIVATE CLAIM

Completed forms can be dropped off at our office or faxed to 667-8740

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8 **Telephone:** (867) 667-5645 **Toll free:** 1-800-661-0443 **Fax:** (867) 667-8740 **Web:** www.wcb.yk.ca

If you recovered from your work-related injury, your file is currently closed. Please complete this form. This information will help determine your eligibility for benefits.

ABOUT YOU

Last Name	First Name	Date of Birth (d/m/y)
Address		Postal Code

Home Telephone #	Cell #	Business #
Claim #	Present Employer	Worker's Occupation

ABOUT YOUR INJURY AND/OR CONDITION

Please describe your original injury (part or parts of body affected; how the original injury happened).

Please describe your CURRENT SYMPTOMS (part or parts of body affected, any changes in symptoms).

When did you first notice your current symptoms?

Have you had a new incident or injury to the same body part since the initial work-related injury? ☐ Yes ☐ No

If ***Yes***, did this new incident or injury happen at work? ☐ Yes ☐ No

- If ***Yes***, you are required to make a new claim for compensation. Please complete and submit a new Worker's Report of Injury/Illness
- If ***No***, (i.e. you had a new injury but it did not happen at work) please describe the injury and provide the date of the incident:

ABOUT YOUR MEDICAL TREATMENT

Has your current condition been diagnosed? ☐ Yes ☐ No

If ***Yes***, what is the diagnosis? _____

Please specify what assistance you are seeking if your claim is reactivated (e.g. medical benefits, loss of earnings benefits, medical treatment, medical devices, etc.)

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TREATMENT DETAILS

Please provide the details of the service providers who have given you medical treatment for the body part(s) (e.g. family physician, physiotherapist, chiropractor, acupuncture, psychiatrist or psychologist, specialist, surgeon, hospitals, imaging (ie. xray, MRI, CT), etc.)

Service/Treatment Provider (Name/Address/Phone #/Fax #)	Treatment Date(s) (Month/Year)	Type of Treatment

ABOUT OTHER BENEFITS

Have you applied for, or are you receiving any of the following:

- ☐ Old Age Security Pension
- ☐ Retirement Pension

Have you had or do you have any claims for the body part(s) stated in this form with any other Workers' Compensation Boards in Canada?

- ☐ Yes
  Where? _____
- ☐ No

ABOUT YOUR INFORMATION

I declare that the information provided is true and correct. I consent to the release from any source including the Canada Revenue Agency to the Workers' Safety and Compensation Board (WSCB) of any medical or employment information relevant to my claim. I consent to WSCB disclosing to healthcare providers, hospitals, physicians, my employers, other workers' compensation boards, Canada Revenue Agency and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

I acknowledge that the YWCHSB may collect information it considers relevant to my claim to determine benefit entitlement and 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 in accordance with the law.

Signature _____ Date (d/m/y) _____

Note: 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.