Yukon Workers' Compensation Health and Safety Board

APPLICATION FOR EXTENDED COVERAGE OUTSIDE CANADA

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

If you are sending workers outside Canada, submit your application as soon as possible. A decision may take up to 30 days. Workers who leave Canada before a decision has been made on this application will not be covered by YWCHSB. See YWCHSB Policy EA-14, "Coverage for Workers Outside Yukon", for more information.

EMPLOYER INFORMATION

Customer #	Business name	Authorized contact
Phone	Fax	Email*

ABOUT THE WORK PLANNED

Exact location (province/territory/state, country)

Description of work planned

ABOUT THE WORKERS – List workers who will be covered outside of Canada. If you require more space, please attach another sheet.

Full legal name of worker	Years/months employed by this employer in Yukon	Departure date	Return date	I have verified this worker is a Yukon resident
		YYYY/MM/DD	YYYY/MM/DD	☐ Yes ☐ No
		YYYY/MM/DD	YYYY/MM/DD	☐ Yes ☐ No
		YYYY/MM/DD	YYYY/MM/DD	☐ Yes ☐ No

EMPLOYER RESPONSIBILITIES

Confirm that the following actions have been taken:

- The work we have planned outside Canada is a continuation of the work we do in Yukon. ☐ Yes ☐ No
- We have purchased workers' compensation coverage in the foreign jurisdiction. ☐ Yes ☐ No

About your workers' health and safety while working abroad:

- I have verified my workers will have access to health care services comparable to Yukon. ☐ Yes ☐ No
- I have verified there are no concerns with civil disorder or my workers' personal safety and security where they will be working. ☐ Yes ☐ No
- I have trained my workers on actions to take if a workplace injury occurs outside Canada. ☐ Yes ☐ No

Note: *A worker or dependent of a deceased worker must claim compensation from YWCHSB within 30 days of an injury that occurs outside Yukon, or it is assumed they will be claiming in the jurisdiction where the injury occurred. Employers are required to report medical and time loss injuries to YWCHSB within 3 days of the injury.*

DECLARATION

I *[print name]* _____ declare that the above information is true and correct to the best of my knowledge and that I am authorized to sign this application on the employer's behalf. I acknowledge that I have read and understand my responsibilities. I am authorized to permit travel outside of Canada on the employer's behalf.

_____	_____	_____
Authorized contact signature	Position title	Date

Application ☐ Approved ☐ Denied

_____	_____
Director of assessments	Date

Employers have the right to appeal any assessment-related decision to the Board of Directors within 180 days of the decision under Section 85 of the *Workers' Compensation Act* S.Y. 2008. This information is being collected for the purposes of administering and enforcing the *Workers' 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 YWCHSB at the above listed address or at 867-667-5645 or 1800-661-0443. *By providing your email address, you permit YWCHSB to correspond with you by email. To withdraw your email from our system, contact us.

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