Yukon Workers' Compensation Health and Safety Board

Optional Coverage Application Form for Volunteers

Name:_____ Customer #: _____

I understand and acknowledge that in the event of a time-loss claim for a work-related disability, loss of earning benefits will be paid at a rate of 75% of actual proven earnings. Actual proven earnings under the policy will be based on the greater of the policy coverage amount purchased[1] and in place at the time of the injury or actual proven earnings, up to the Maximum Wage Rate as established by the Yukon Workers' Compensation Health and Safety Board (YWCHSB) for the year of coverage. Other sources of assessable income from concurrent employment will be considered in addition to the Optional Coverage earnings protection.

_____ Please Initial As Confirmation of Having Read the Above Section

- The Employer or their Authorized Agent must sign the application,
- Coverage will not begin until the Yukon Workers' Compensation Health and Safety Board (YWCHSB) *approves this signed application form of* the employer or their authorized agent.
- The optional coverage is for volunteers such as volunteer firefighters.
- This application must include the written consent of the individual being covered (see below).
- The minimum amount of coverage that may be purchased is one-half the maximum wage rate established for the year of coverage.
- In the event of a time-loss claim resulting from a workplace disability, proof of earnings must be based on tax returns, T-4 slips, or payroll stubs.
- If the sum of all proven earnings is less than one-half the maximum wage rate, then the benefits will be based on one-half the maximum wage rate. If the sum of all actual proven earnings is greater than one-half the maximum wage rate, then the benefits will be based on actual earnings.
- Coverage may be purchased for a period of time less than one year and must be renewed annually at the end of each calendar year. If your work is year round, your compensation coverage must be renewed annually for the end of each calendar year.
- The minimum assessment premium for Optional Coverage for each individual, regardless of the period of time that coverage is in place, is $150.00 per year.

NOTE: See attached sheet to list Optional Coverage for up to 10 Volunteer workers. Additional forms are available upon request.

EMPLOYERS CERTIFICATION: I _____certify the information
(Print name)
provided by me on this form is true and completed to the best of my knowledge and agree to the terms and conditions of Optional Coverage.

_____ Date _____
Signature-Employer or authorized representative

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1. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

[1] The amount of policy coverage purchased for volunteers **cannot** be less than ½ the Maximum Wage Rate for the year of coverage.

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 1-800-661-0443.

2. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

3. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

4. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

5. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

6. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

7. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

8. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

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9. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

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10. Optional coverage for: _____Requested coverage: $45,375.00 or_____
(Print employee name) (specify greater amount)

Begins : _____ to Ends:_____
Year/Month/Day Year/Month/Day

_____
Signature of worker

For more information please contact our office on business days between Monday through Friday, 8 am and 5 pm at:

Yukon Workers' Compensation Health and Safety Board
401 Strickland Street
Whitehorse, Yukon
Y1A 5N8

Phone: 1-867-667-5095
Toll Free: 1-800-661-0443
Fax: 1-867-393-6279
Email: wchsb-assessments@gov.yk.ca