

**Optional Insurance  
Request/Change**

<b>Please complete this section.</b>	
Account No.	Firm No.
Telephone Enquiry Number	
<b>(416) 344-1000</b> <b>1-800-387-0080</b>	

If you are **requesting** optional insurance or **changing** the amount of existing optional insurance, please:

- complete the sections **A** and **B** (for new requests) or **C** (for changes)
  - provide proof of earnings (see below)
  - have the applicant review and sign the Optional Insurance Declaration (attached)
  - have the Owner's Certification completed and signed (attached)
- Individuals who are canceling their optional coverage must complete section **D**, or forward their request in writing to their local WSIB office. The WSIB accepts the following documents as **proof of earnings**, issued by the owner or authorized officer responsible for this account.

**For Executive Officers**

- T4s and T4As or any other document submitted to Canada Revenue Agency (CRA) to report earnings.

**For Independent Operators, Sole Proprietors and Partners**

- Audited financial statements prepared by a professionally designated accountant
- Income tax returns with supportive income statements (T1, T2124, T2032, etc.) or other documents submitted to Canada Revenue Agency to report business income.
- If the applicant's company has been in business for **less than one (1) year**, the amount of coverage for premium and benefit purposes is set at 1/3 of the annual maximum insurable earnings.
- If the applicant's company has been in business for **more than one (1) year**, the amount of coverage for premium and benefit purposes must accurately reflect the applicant's actual annual earnings, as supported by documents listed above.
- Coverage will not be provided if your operation shows a **net business loss**.
- Loss of earnings benefits are not paid if your operation shows a **net business loss**, despite active optional insurance.

If the level of earnings cannot be substantiated, the WSIB may deny the request for optional insurance.

The WSIB may deny coverage (or coverage renewal) or cancel coverage in the absence of acceptable proof of earnings.

Any change to the amount of optional insurance will take effect on the date the signed request and satisfactory proof of earnings are received by the WSIB.

The WSIB may require prepayment for optional insurance premiums.

If the applicant is paid benefits at an amount that is lower than the amount of optional insurance, the amount of optional insurance will not be retroactively adjusted.

If you have any questions or require more information, contact your WSIB account representative. If you do not know the phone number, please call the WSIB at the telephone number listed at the top of this form.

**A. You must complete this section.**

First Name		Middle Name	Last Name	
Date of Birth (dd/mmm/yyyy)	Social Insurance Number	Title/Position with Company		
Home Address (This address must be a physical address, not a box number or general delivery)				City
Province	Postal Code	Area Code ( )	Telephone No.	Date Business Commenced (dd/mmm/yyyy)

**B. Complete only if the applicant is requesting new optional insurance.**

Amount of Coverage Requested \$	Today's Date (dd   mmm   yyyy)	Applicant's Signature (must be signed)
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**C. Complete only if the applicant is requesting a change in the amount of existing optional insurance.**

Revised Coverage Amount Requested \$	Today's Date (dd   mmm   yyyy)	Applicant's Signature (must be signed)
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**D. Complete only if the applicant is canceling existing optional insurance.**

Name	Today's Date	Signature (must be signed)	Name	Today's Date	Signature (must be signed)

## Optional Insurance Declaration

**Please read the following information carefully. It explains how Optional Insurance changes your status under the Workplace Safety & Insurance Act ("the Act").**

**I understand that:**

1. Owners, partners, executive officers and independent operators are not automatically entitled to benefits under the Act.
2. I am voluntarily requesting to be considered a worker by the WSIB by applying for optional insurance.
3. I must have optional insurance for a minimum of three (3) consecutive months.
4. With optional insurance, I am eligible to claim for benefits.
5. I am giving up my right to sue workers and employers whose industries are covered under Schedule 1 of the Act for damages sustained in a workplace injury.
6. I must send the WSIB proof of earnings when first requesting optional insurance.
7. If my earnings level changes, I must send the WSIB a signed request to revise the amount of insurance coverage, along with proof of earnings.
8. The WSIB may deny my request for coverage if I do not provide acceptable proof of earnings.
9. The WSIB may request proof of earnings at any time.
10. The WSIB may adjust the amount of optional insurance that I request.
11. My optional insurance will continue beyond the minimum three (3) months until either the WSIB or I cancel the insurance.
12. If I have a workplace injury, my optional insurance will remain in effect until the WSIB receives my signed notification to cancel it.
13. If I have a workplace injury, my earnings at the time of my injury will be compared to the amount of my optional insurance. The WSIB will base benefits on whichever is the lower amount - my earnings or my optional insurance coverage.
14. If I am paid benefits at an amount that is lower than the amount of my optional insurance, the amount of my optional insurance will not be retroactively adjusted.
15. The WSIB may refuse, cancel or deny renewal of my optional insurance if the employer paying for it is in arrears. If any premium is owing on my optional insurance, the amount of the unpaid premium may be deducted from my benefits.
16. The effective date for new optional insurance requests, changes to or cancellations of optional insurance will either be the date that the completed form 1574A is received by the WSIB, or the requested date, whichever is later.

Applicant's Name	Applicant's Signature	Date (dd/mmm/yyyy)
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### Owner's Certification

**I hereby certify that I am an owner (or authorized officer) responsible for this account. I also certify that the amount of optional insurance requested accurately represents the earnings of the applicant.**

**I acknowledge that the costs associated with any work-related injuries or occupational diseases for the applicant will be applied to the accident record for this account.**

**Personal information on this form is collected under the authority of the Workplace Safety and Insurance Act, and may be used to register/determine your status for coverage and to administer and enforce the Act. If you have any questions, please contact your WSIB account representative or call 1-800-387-0080.**

Name of Owner or Authorized Officer	Title		
Signature	Area Code (      )	Telephone Number	Date Completed (dd/mmm/yyyy)

**For Office Use Only:**

WSIB Representative	Date (dd/mmm/yyyy)	Amount of Coverage \$	Effective Date (dd/mmm/yyyy)
<input type="checkbox"/> Proof of earnings received <input type="checkbox"/> Proof of eligibility received <input type="checkbox"/> Actual earnings used <input type="checkbox"/> 1/3 of maximum insurable earnings used			