WORKPLACE SAFETY INSURANCE BOARD (WSIB) INFORMATION FORM

Send to: CCWUcare | 200 Labourers Way, Suite 2100 | Vaughan, ON L4H 5H9
P: 416.240.0047 | F: 416.240.7488 | w: www.ccwucare.com | e: info@ccwucare.com

A Member Information (Please Print)

Last Name First Name	Gender ☐ Male ☐ Female
Address	Date of Birth (yyyy/mm/dd)
Town/ City Prov. Postal Code	Country
Member Advantage Benefit Card ID Number (last 10 digits)	*Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID*
Email Address	Phone #
Marital Status ☐ Married ☐ Common-Law ☐ Single ☐ Separated ☐ Divorced ☐ Widow	Cell #

B Claim Information (Please Print)

W.S.I.B. Claim No.: _____

Company Name: _____

Name of Employer: _____

Location of Accident: _____

Date of Accident: _____

C Employer Disclosure Authorization

Please complete and return this form with your monthly remittance to:

CCWUcare
C/O Benefit Plan Administration Limited
205 - 1263 Wilson Ave.
Toronto, ON, M3M 3G2

*Failure to send this form in may result in your employee being denied fund assistance.

Employer Name: _____ Date: _____
(Print Name)

Employer Signature: _____ Witness: _____

Please complete, print, sign, and return by fax at 416.240.7488 **OR** email to info@ccwucare.com