Acknowledgement of consent to use email

Submit this form and supporting documents at wsib.ca/submit

If you are objecting to a decision or requesting a copy of your claim file, the WSIB will provide the file and any relevant forms electronically. Receiving claim information by email means you receive your documents faster, letting us help you more quickly.

By filling out this form, you acknowledge and accept the risks of electronic communication. Risks may include, but are not limited to, misdirected emails or emails received by an unintended recipient, intercepted, altered or forwarded without detection, or introducing viruses into computer systems. Appeal information may include confidential claim information including, but not limited to, medical information and decisions relating to benefits.

You are responsible for updating the WSIB if the email address you provide changes or if there is a security concern related to the email address you provide on this form. It is also your responsibility to protect your password or other means of access to electronic communications sent to or received from the WSIB.

While the WSIB will take reasonable steps to protect the confidentiality of the communication it transmits via email, by providing your consent, you acknowledge that the WSIB cannot guarantee the security and confidentiality of all email communications and has no responsibility for your account security, or the security of the electronic communications stored in your email account.

First name	Last name	Claim number
Company name (if applicable)		
Role ☐ Claimant ☐ Claimant representative ☐ Business ☐ Business representative		
Email address		

Acknowledgment and signature		
I confirm I read this form carefully and understand the risks and responsibilities associated with the use of email. By signing below, I agree to assume all risks associated with the use of email.		
Name	Signature	Date (dd/mmm/yyyy)
☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.		

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.
Ce document est disponible en français sous le titre : *Confirmation du consentement à l'utilisation des courriels,* 10467B (04/23)

wsib ONTARIO

Worker request for copy of claim file

Submit this form and supporting documents at wsib.ca/submit

Claim number

Please complete a separate form for each claim requested. If you have previously received a copy of your claim file, you will receive updates to your file from the date of your last request. If you are considering objecting to a WSIB decision that denies benefits, please contact your decision-maker to discuss your concerns. Should you decide to proceed with an appeal, you will be automatically provided with a copy of your claim file.

Worker information (This section is mandatory, please complete all fields.)			
Last name	First name		Claim file no.
Address (no., street, apartment/suite)			City/Town
Province	Postal code	Country	Telephone
Email address	Date of birth (dd/mmm/yyyy)	Date of injury/illness (dd/mmm/yyyy)	

Please choose one option:

☐ I am requesting that a copy of my claim file be sent to me.

OR

☐ I am requesting that a copy of my claim file be sent to a third party listed below. (Please complete section below)

Personal information contained on this form is collected under the Workplace Safety and Insurance Act and will be used to respond to your request. The WSIB will provide the file and any relevant forms electronically to the email you provided. By providing an email address, you acknowledge and accept the risks of electronic communication.

Signature of worker	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Third-party information (required if requesting a copy to be sent to a third party.)			
If you are represented, a signed *Direction of Authorization* for this representative must be submitted to your claim file			
Name of third party			
Name of organization/firm			
Address (No., street, apartment/suite)			
City/Town	Province	Postal code	Country
Telephone	Email address		

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.
Ce document est disponible en français sous le titre : *Demande de copie du dossier d'indemnisation (travailleuse ou travailleur),* 2144B (04/23)