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Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Intent to Object Form

print reset save

If you need assistance completing this form, see the instruction sheet or call the WSIB at 416-344-1000 or 1-800-387-0750.

1. Claim Identifiers

start >

Worker's Name	Claim No.

2. Objecting Party

☐ Worker ☐ Worker Representative ☐ Employer ☐ Employer Representative ☐ Transfer-of-Cost Employer

3. General Information

Is the worker/employer address and contact information the same as the decision letter? ☐ **Yes** ☐ **No, see changes below.**

Name		
Address	City/Town	Postal Code

Telephone No.: (Day)	Telephone No.: (Evening)	Language
( )	( )	☐ English ☐ French ☐ Other _____

4. Representation

See Instruction Sheet for information on possible assistance available.

Please check one: ☐ **I will represent myself in the objection process, or I am currently seeking representation.** ☐ **I have a representative to handle my objection.**

If you are represented - A signed *Direction of Authorization* for this representative must be in the claim file.

Representative's Name	Organization	
Address	City/Town	Postal Code

Telephone No.: (Day)	Telephone No.: (Evening)	FAX No.
( )	( )	( )

5. Intent to Object

I disagree with the following decision(s):

Date of Decision Letter(s) (dd/mmm/yyyy)	**Issue(s) in Dispute**

6. New Information/Reconsideration

This is an opportunity to provide any new information that the front-line decision maker may not have considered, based on the contents of the decision letter(s). The decision maker can reconsider the decision(s) and may be able to change the decision(s). You will be advised of the outcome of the reconsideration.

☐ **No, I have no additional explanation/information to submit.**

☐ **Yes, additional explanation/information is attached.**
(Please put the worker's name and claim number on each page.)

Name (please print)	Signature	Date

Please print and sign the completed form before sending to the WSIB by fax to **416-344-4684 or 1-888-313-7373** or by mail to: Workplace Safety & Insurance Board, 200 Front Street West, Toronto, ON M5V 3J1

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(Optional Page)

Worker's Name	Claim No.

7. Reasons for the Objection

Please explain why you disagree with the decision(s). Your explanation may bring out new information the front-line decision maker was not aware of. Be as specific as possible and refer to any new information you are attaching, where applicable. Please attach additional pages if you need additional space.

	Number of pages attached