



Complete this form in full and return to WorkSafeBC.

**CLAIMS CALL CENTRE**

Phone 604 231-8888  
Toll-free 1 888 967-5377  
M–F, 8:00 a.m. to 4:30 p.m.

**FAX**

**604 233-9777**  
Toll-free **1 888 922-8807**

**MAIL**

WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

**Deceased worker's information**

Worker last name	First name	Middle initial	WorkSafeBC claim number
Date of injury (yyyy-mm-dd)		Date of death (yyyy-mm-dd)	

**Part A**

I am the spouse/dependent of the late \_\_\_\_\_, (full name), who died as a result of a work-related injury or occupational disease on the \_\_\_\_\_ day of \_\_\_\_\_, (e.g. 15th) (month), in \_\_\_\_\_, (year) \_\_\_\_\_ (town/city and province/state).

Under the *Workers Compensation Act* of British Columbia, I must choose whether I will:

- claim compensation or sue the responsible parties; or
- claim compensation under the workers' compensation system of the province or territory where the injury, exposure, or death occurred; or
- claim compensation under the law of the country or place in which the injury, exposure, or death occurred.

Having considered the matter I, \_\_\_\_\_, (full name), hereby elect to claim compensation from the Workers' Compensation Board of British Columbia for myself, and (if applicable) on behalf of my child(ren):

1.	Full name of child	Date of birth (yyyy-mm-dd)
2.	Full name of child	Date of birth (yyyy-mm-dd)
3.	Full name of child	Date of birth (yyyy-mm-dd)
4.	Full name of child	Date of birth (yyyy-mm-dd)
5.	Full names and dates of birth of additional children	

Have you applied for or received benefits from another province or jurisdiction? Yes  No

Should my claim be accepted, I waive and forego my rights to compensation with any other jurisdiction or place/country, and will not apply for or accept any benefits from such other jurisdiction unless released to do so by the Workers' Compensation Board of British Columbia.

Signature of spouse/dependent	Signature date (yyyy-mm-dd)	Town/city and province
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**Complete Part B if the injuries sustained were the result of a motor vehicle accident.**





Worker last name	First name	Middle initial	WorkSafeBC claim number
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**Part B — Traffic accident information** *(if applicable)*

Where did the accident happen? <i>(intersection/place/address, town/city, province/state, country)</i>		Date of accident <i>(yyyy-mm-dd)</i>
Full name of the driver of the other vehicle		Address of the driver of the other vehicle
Town/city	Province/state and country	Postal/zip code
ICBC or insurer's claim number		
ICBC or insurance adjuster's name		ICBC or insurance adjuster's phone number <i>(include area code)</i>
ICBC or insurance claim centre location and address		
Have you received any ICBC benefits or benefits from an insurer? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Which police or law enforcement department (if any) came to the accident?		
Police or law enforcement department's case number	Were charges laid? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.

