

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				
Last Name		First Name		Claim File No.
Street No.	Street Name		Apt./Suite No.	Town/City
Province	Postal Code	Country		Telephone
Date of Birth (dd/mmm/yyyy)			Date of Injury/Illness (dd/mmm/yyyy)	
Please choose one option:				
<input type="checkbox"/> I am requesting that a copy of my claim file be sent to me at the above address.				
OR				
<input type="checkbox"/> 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.				
Signature of Worker				Date (dd/mmm/yyyy)

Third Party Information				
Information required if requesting copy to be sent to a Third Party.				
Name of Third Party				
Name of Organization/Firm:				
Street No.	Street Name		Apt./Suite No.	Town/City
Province	Postal Code	Country		Telephone

If you encounter any difficulties or have questions regarding this request for access, you may contact us at (416) 344-1000 or toll-free at 1-800-387-0750.

Visit our Web site www.wsib.on.ca for information on benefits, services, working safely and more.