



ELECTION UNDER THE ACT RESPECTING INDUSTRIAL ACCIDENTS AND OCCUPATIONAL DISEASES
(SECTION 452 OF THE ACT)
Occupational health and safety

Identification of the Worker			
Surname (as shown on birth certificate)		First name	Telephone
Address	No	Street	
City, Municipality		Province, Country	Postal code
Date of Birth	Date of Event	Social Insurance Number	Worker's file No.
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I, _____, declare that I suffered an employment injury
(Worker's name)
 on _____, in _____ when I was working
(Day, Month, Year) (Province, Territory or, if outside Canada, Country)
 for _____
(Employer's name and address)

Or (in case of death)

I am the _____ of _____ who died on
(Spouse, Dependent, Father, Mother, Succession) (Worker's name)
 _____ following an employment injury sustained in _____ while
(Day, Month, Year) (Province, Territory or, if outside Canada, Country)
 working for _____
(Name and Address of Employer)

I must choose between the benefits provided under the Act respecting industrial accidents and occupational diseases (Quebec Act) and the benefits provided under the laws of _____.
(Province other than Québec, Territory or, if outside Canada, Country)

I declare that I am making a claim for this employment injury with the _____ Board
(Province, Territory or, if outside Canada, Country)
 and I am advising the Commission des normes, de l'équité, de la santé et de la sécurité du travail accordingly.
 I also declare that I have not claimed for compensation from another organization for the same employment injury.

If this claim is accepted, I waive in relation to this employment injury all rights to compensation under any other legislation.

Signature: _____ Date: _____
(Worker or, in case of death, beneficiary) (Day, Month, Year)