

The Workers Compensation Act of Prince Edward Island  
Election to Claim Compensation

Claim Number: \_\_\_\_\_

I \_\_\_\_\_ sustained personal injury or occupational disease on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ in the province (or territory) of \_\_\_\_\_ while in the employ of \_\_\_\_\_.

OR (in the case of death)

I am a dependant of \_\_\_\_\_, who died on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ as a result of a work related injury or occupational disease sustained in the province (or territory) of \_\_\_\_\_.

I must choose whether I will claim compensation under the Workers Compensation Act of \_\_\_\_\_ or claim compensation under the law of the province (or territory) of \_\_\_\_\_, where the injury (or occupational disease or fatality) occurred.

Having considered the matter, I elect to claim compensation for this injury (or occupational disease or fatality) under the Workers Compensation Act of \_\_\_\_\_.

Should my claim be accepted, I waive and forego any rights to compensation in any other jurisdiction and will not apply for or accept any benefits from such other jurisdictions unless authorized to do so by the jurisdiction in which I elect to claim.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, at \_\_\_\_\_.

Signature of worker (or dependent in case of fatality) \_\_\_\_\_

Signature of witness \_\_\_\_\_

Information on this form is required for the purposes of administering the *Workers Compensation Act* and collected under the authority of section 31 of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about this collection of information, please contact: FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7, (902) 368-5680 or toll free at 1-800-237-5049