Safety Matters @Work
Workers Compensation Board of PEI

AUTHORIZATION FOR REASSIGNMENT

P.O. Box 757, 14 Weymouth Street, Charlottetown, PE C1A 7L7 www.wcb.pe.ca
Phone: (902) 368-5680 Toll-free: 1-800-237-5049 Fax: (902) 368-5696

Claim #	

Worker's Name	**Telephone Number**
Address	**City/Province**
	Postal Code

Name of Representative:	
Address of Representative:	
Signature of Representative: (not required for option B)	

Option A:

☐ **I hereby authorize the Workers Compensation Board to release my cheques to the representative indicated on this form. This authorization shall be in place from this date until I cancel the authorization in writing.**

Option B:

☐ **I hereby authorize the Workers Compensation Board release the portion of Workers Compensation Benefits due to me totalling the amount indicated on this form.**

Total Amount Authorized:	

Worker's Signature:	
Date:	

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

INSTRUCTIONS

1. Claim #:
   Enter the Claim Number of the worker making the appointment.

2. Workers Name:
   Enter the name of the worker making the appointment.

3. Address/City/Province/Postal Code/Telephone Number:
   Enter the contact information of the worker making the appointment.

4. Name of Representative:
   Enter the name of the representative to whom the benefits will be released.

5. Address of Representative:
   Enter the address of the representative to whom the benefits will be released.

6. Signature of the Representative:
   Have the appointed representative sign the form. For option B, the signature is optional.

7. Option A:
   Check the box under option A if all cheques will be released to the authorized representative for a period of time.

8. Option B:
   Check the box under option B if a portion of benefits will be released to the authorized representative.

9. Total Amount Authorized:
   For option B, enter the total amount to be released.

10. Workers Signature:
    The worker signs the form.

11. Date:
    The worker dates the form with the date of the signature.