WSIB Ontario | General worker expense form

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

A. Worker information				
Last name	First name			Initial
Current address	City		Province	Postal code
Is this a new address ☐ Yes ☐ No	Home phone	Work phone	Birth date (dd/mmm/yyyy)	

B. Expense information

- Original receipts plus prescriptions must be attached.
- This form is not to be used for medication reimbursement.

Description of service/product	Quantity	Who recommended this for you (name, address and phone number)	Date purchased/ of service	Amount ($)

Additional comments	Total

C. Worker declaration

I hereby certify, that to the best of my knowledge, the information provided on this form is true, accurate and complete, and that the goods and/or services listed were received by myself for my use and for my WSIB related claim. I agree to provide all original receipts to the WSIB. For the goods and/or services paid for by the WSIB, I will not request reimbursement from any other insurers/organizations. I also authorize the release of any information to the WSIB relating to the expenses listed on this form.

Name	Signature	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.