WorkplaceNL

MAILING ADDRESS:
P.O. Box 9000
St. John's, NL A1A 3B8

EMAIL OR FAX FORM TO:
esa@workplacenl.ca
709.778.1110

CALL US AT:
709.778.1140
1.800.563.9000

VISIT US AT:
workplacenl.ca

Optional Personal Coverage Application 2025

The proprietor or partners of a non-incorporated business are not automatically covered under the **Workplace Health, Safety and Compensation Act, 2022**. This means they cannot receive benefits from WorkplaceNL in the event of a work-related injury; however, they may apply for Optional Personal Coverage. Please read the Terms and Conditions before completing this application.

Firm Number	Description of Work	NIC Code	2025 Rate

Full Name	Address	City	Postal Code
Telephone	Fax		

1. Optional Personal Coverage is effective from the date of application or from the coverage date requested in the application, whichever is latest. The premium has to be paid in full for coverage to be valid.

2. Optional Personal Coverage assessment premiums must be paid in full, in advance. Payment must accompany the application or the application will not be accepted. The minimum coverage period is 28 days. The range of daily coverage is $32.88 (minimum amount) per day up to $217.38 (maximum amount) per day. Calculate the required payment as follows: **Amount of Daily Coverage X Number of Days X 2025 Rate ( ) /100** (For example, minimum coverage of **$32.88 X 28 Days X $6.00 (i.e. rate) /100 = $55.24)** Note, if this calculation results in a payment that is less than $50.00, a nonrefundable minimum assessment charge of $50.00 applies.

3. Optional Personal Coverage automatically expires on December 31 of each year or on the last coverage date requested by the applicant, whichever is earliest. A new application is required if the applicant wishes to continue coverage after the expiration date.

4. If the applicant suffers a work-related injury, proof of earnings must be submitted with the claim for lost wages. Lost time benefits will be paid only on the amount of demonstrated gross earnings but in no situation will they exceed the amount of coverage requested by the applicant. Earnings loss benefits are calculated and paid based upon 85% of net earnings.

5. Application must be signed by applicant or coverage cannot be purchased.

Period of Coverage

From:	To:	Daily amount	Total amount of coverage	Total premium
Year Month Day	**Year Month Day**	$	$	$

Where to Submit Form and Payment

St. John's Office:
146-148 Forest Road
P.O. Box 9000 St. John's, NL, A1A 3B8
t 709.778.1140 t 1.800.563.9000

Grand Falls-Windsor Office
26 High Street
P.O. Box 850 Grand Falls-Windsor, NL, A2A 2P7
t 709.489.1600 t 1.800.563.3448

Corner Brook Office
Suite 201B, Millbrook Mall 2 Herald Avenue,
P.O. Box 474 Corner Brook, NL, A2H 6E6
t 709.637.2700 t 1.800.563.2772

Applicant's Authorization

I declare that this application is complete and correct and understand that giving false information or omitting relevant information is a serious offence.

Signature of Applicant	Date

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toll-free: 1.800.563.9000
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workplacenl.ca

Please FAX or MAIL with copy of void cheque to:
Attn: Assessment Services Department

Optional Personal Coverage
Pre-Authorized Debit (PAD) Agreement

Employer Information (Please print clearly)

☐ **Check here to use this form to request changes to your banking information**

Employer Name		Firm Number	
Phone	Fax		
Mailing address			
City/town		Province	Postal code

Bank Account Information (Please attach copy of VOID cheque)

Financial Institution (FI) Name:_____

FI Branch Address:_____

FI Account Number:_____ ☐ Chequing account or ☐ Savings Account

FI Number: ☐☐☐ *(3 digits)* FI Branch Transit Number: ☐☐☐☐☐ *(5 digits)*

Pre-Authorized Debit (PAD) Details

I authorize WorkplaceNL to debit the bank account identified above for the full outstanding balance, in a single payment at least the next business day following the date of the Optional Personal Coverage is processed. WorkplaceNL will obtain my authorization for any additional one-time or sporadic payments.

_____
Authorized Signature *(for FI account)*

_____
Second Authorized Signature *(if applicable)*

_____
Name *(Please Print)*

_____
Name *(Please Print)*

_____
Date (*YYYY/MM/DD*)

_____
Date (*YYYY/MM/DD*)

Optional Personal Coverage
Pre-Authorized Debit
(PAD) Agreement

General Information

You the payer may revoke your pre-authorized debit (PAD) authorization at any time by calling 709.778.1125 (or 1.800.563.9000 extension 1125) at least three business days before your next pre-authorized debit payment. To obtain a sample of the industry cancellation form, which you may also use to cancel your PAD authorization provided we receive it at least 30 days before your next pre-authorized debit payment, or for more information on your right to cancel a PAD Agreement, please contact your financial institution or visit **www.payments.ca.**

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit **www.payments.ca.**

Important: You must contact us if any of the information you provide on this form changes.

Contact us

For more information, call 709.778.1125 or 1.800.563.9000, ext 1125.