**Election Form (Schedule 1)**

**Claim number**

1. My full name is (claimant name).
2. I experienced a workplace accident on (date of injury).

OR

2(b) I am the (please state your relationship to the deceased person - i.e., spouse, sibling, child, parent) of (person’s name) who died due to a workplace accident on (date of injury).

1. I understand that, under the *Workplace Safety and Insurance Act*, I can claim WSIB benefits OR bring a lawsuit against the person(s) who may have caused the workplace accident. I cannot do both. I also understand that I have the right to seek independent legal advice before signing this form.

4. I am choosing the following option (check the box next to the option you are choosing):

**Option 1 - Claiming WSIB benefits**

By choosing this option, I confirm and understand that I can no longer start a lawsuit on my own against anyone involved in this accident. My right to start any lawsuit resulting from this workplace accident is transferred to the WSIB.

**□ Option 2 - Not claiming WSIB benefits**

By choosing this option, I keep the right to bring a lawsuit.

**Only complete questions 5 and 6 for motor vehicle collisions**

1. The motor vehicle collision happened:

In Ontario Outside Ontario in the province or state of .

6. Please confirm by checking the appropriate boxes.

(a) Have you applied for benefits from a car insurance company? No Yes

(b) If yes, have you received benefits from the car insurance company? No Yes