

## Instructions

You will receive workplace insurance compensation if you are:

- A student enrolled in an Approved Postsecondary Program;
- Injured or contracted a disease while on an Unpaid Work Placement; and
- Eligible for workplace insurance compensation as determined by,
  - the WSIB, if your Placement Employer is covered under the WSIA (WSIB 416-344-1000); or
  - CHUBB, if your Placement Employer is not covered under the WSIA (CHUBB 1-877-772-7797).

Claims under the WSIA are made by submitting the following required documents to WSIB, with copies to Ministry of Colleges and Universities:

- a WSIB Form 7;
- the letter of authorization; and
- *Postsecondary Student Unpaid Work Placement Workplace Insurance Claim Form* completed by the student, the Placement Employer and the Institution.

If your Placement Employer is not covered under the WSIA, your eligibility for and payment of workplace insurance compensation will be determined by Chubb Insurance Company of Canada. Claims under CHUBB are made by submitting a CHUBB designated form, completed in accordance with the CHUBB instructions, with a copy to Ministry of Colleges and Universities.

In this form:

- “CHUBB” means the Chubb Insurance Company of Canada, a private insurer retained by the Government of Ontario.
- “Approved Postsecondary Program” means a postsecondary program offered by an Ontario college of applied arts and technology or an Ontario publicly assisted university, and funded through operating grants provided by the Ministry of Colleges and Universities.
- “Institution” means the Ontario college of applied arts and technology or Ontario publicly assisted university at which the student is enrolled.
- “MCU” means the Ontario Ministry of Colleges and Universities.
- “Placement Employer” means the employer providing the Unpaid Work Placement.
- “Unpaid Work Placement” means an unpaid work placement that is part of an Approved Postsecondary Program.
- “WSIA” means the *Workplace Safety and Insurance Act, 1997*.
- “WSIB” means the Workplace Safety and Insurance Board.

Note to Institution: As identified in the MCU **Guidelines for Workplace Insurance for Postsecondary Students of Publicly Assisted Institutions on Unpaid Work Placements**, it is your responsibility to inform students before they commence an Unpaid Work Placement that if they are injured while on an Unpaid Work Placement, the Institution will disclose their personal information to MCU, if relevant to a workplace insurance compensation claim.

## A. Parties Consenting to the Unpaid Work Placement

1. Name of student		
Last name	First name	Middle name
Student number	Email address	Telephone no.
2. Name of Placement Employer		
Name of Training Supervisor		
Last name	First name	Middle name
Email address	Telephone number	
<input type="checkbox"/> 2a. Placement Employer is covered under the WSIA, WSIB number: _____		
<input type="checkbox"/> 2b. Placement Employer is covered under the CHUBB		

Completed by Host Organization

3. Firm number	Name of institution	
<a href="#">Select</a>		
Name of contact person		
Last name	First name	Middle name
Email address	Telephone number	

Completed by Trent  
Placement Coordinator

## B. The Approved Postsecondary Program

1. Name of the Approved Postsecondary Program in which the student is enrolled

**C. Student Unpaid Work Placement Schedule**

1. What are the start and completion dates of the student's Unpaid Work Placement?

Start date (yyyy/mm/dd): \_\_\_\_\_ Completion date (yyyy/mm/dd): \_\_\_\_\_ Total days: \_\_\_\_\_

2. What are the normal hours of the student's Unpaid Work Placement?

From (hh:mm): \_\_\_\_\_ To (hh:mm): \_\_\_\_\_ Shift work: ☐ Yes ☐ No

3. What are the normal days of the week of the student's Unpaid Work Placement?

Specify days: \_\_\_\_\_ To: \_\_\_\_\_

If unknown, Host Organization/Student can assist.

**D. Confirmation of Institution**

I, \_\_\_\_\_  
 Last name, first name  
 \_\_\_\_\_ am authorized to complete this confirmation on behalf of the institution.  
 \_\_\_\_\_  
 Position title

I hereby confirm that:

1. I have read the definitions of an Approved Postsecondary Program and an Unpaid Work Placement above.
2. The above-named student was enrolled in an Approved Postsecondary Program offered by the Institution and was injured or contracted a disease during an Unpaid Work Placement relating to that program.
3. The Institution has provided the student with notice that it will be disclosing personal information relating to the Unpaid Work Placement and any WSIB or CHUBB claim to MCU.
4. I have been informed by the Placement Employer that:
  - ☐ a. the Placement Employer has WSIB coverage for the entire period of the placement as indicated in Section C.
  - ☐ b. the Placement Employer is not covered by WSIB for the entire period of the placement as indicated in Section C.

Signature of institution representative

Date (yyyy/mm/dd)

X

**Confirmation of Placement Employer**

Note: This confirmation may be completed by the student's Unpaid Work Placement training supervisor or other person authorized to complete the confirmation on behalf of the Placement Employer.

I, \_\_\_\_\_  
 Last name, first name  
 \_\_\_\_\_ am authorized to complete this confirmation on behalf of the Placement Employer.  
 \_\_\_\_\_  
 Position held

Employer. I hereby confirm:

1. The Unpaid Work Placement Schedule for the above-noted student as identified in Part C above.
2. The student was injured or contracted a disease while on an Unpaid Work Placement with the Placement Employer.
3. The Placement Employer:
  - ☐ a. has WSIB coverage for the entire period of the placement as indicated in Section C.
  - ☐ b. is not covered by WSIB for the entire period of the placement as indicated in Section C.

Signature of Placement Employer Representative

Date (yyyy/mm/dd)

X

**Notice of Collection and Consent of Student**

MCU collects your personal information, directly from you and indirectly from your postsecondary institution, your placement employer and either the Workplace Safety and Insurance Board (the Board) or CHUBB (the Insurer) to administer and finance the payment of your workplace insurance compensation. Administration includes verifying your eligibility, making payments to the Board or the Insurer and evaluating, monitoring and auditing MCU's coverage of workplace insurance compensation.

I hereby confirm the accuracy of the personal information about me on this form and consent to the indirect collection of personal information by MCU.

Signature of student

Date (yyyy/mm/dd)

X

Signature of parent/guardian if under 16

X