Labourers' Pension Fund
OF CENTRAL AND EASTERN CANADA

WORKPLACE SAFETY & INSURANCE BOARD AUTHORIZATION FORM

MEMBER INFORMATION

SIN or LPF Member ID Number	Last Name	First Name and Initial

Date of Birth (dd/mm/yyyy)	Sex (please circle) M F	Email

Address – Is this a new address (please circle) YES NO	City	Prov

Postal Code	Country	Home Phone	Mobile Phone	Work/Daytime Phone

Claim Number(s)	Date of Injury	Name of Employer

AUTHORIZATION AND SIGNATURE

I,____hereby authorize the Labourers'
(print name)

Pension Fund of Central & Eastern Canada (LPF) to request any information from the Workplace Safety and Insurance Board of Ontario or from a correspondent workers' compensation agency of another province concerning my absence(s) from work as identified above as a result of a work-related injury or disability and authorize the Workplace Safety and Insurance Board or the correspondent workers' compensation agency of another province to provide LPF with this information.

Signature	Date (dd/mm/yyyy)

Mailing Address: PO Box 9002, Lakeshore West PO, Oakville, ON L6K 0G1
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