MSI-Be

Mohawk Self Insurance requires this information to assess and determine the benefits in the event of an on the job injury, occupational disease or death. Our insurance benefit actuaries require this information to calculate the dependent and survivor income benefits that your spouse/children could be entitled to, and for Mohawk Self Insurance to sustain the level of quality, and maximum service delivery.

Employer Information:

Employer Name: _____

Employer Address: _____

Employment Date: Start Date: _____ End Date: _____
(Month/Day/Year) (Month/Day/Year; if contracted or seasonal)

Hourly Salary: _____ Weekly Salary: _____

Worker Information:

Worker Name: _____
(First Name) (Last Name)

Sex: ☐ Male ☐ Female Date of Birth: _____
(Month/Day/Year)

Band Number: _____

Medicare Number: _____

Social Insurance Number: _____

Home Telephone Number: _____ Cell Number: _____

Home Address: _____

E-mail Address: _____

Emergency Contact Name: _____ Number: _____

Martial Status: ☐ Married ☐ Divorced ☐ Single ☐ Common Law

Name of Legal Spouse: _____
(First Name) (Last Name)

Date of Birth of Legal Spouse: _____
(Month/Day/Year)

I hereby acknowledge that the information provided is correct and true.

Employee Signature: _____ Date: _____
(Month/Day/Year)