

WORKERS COMPENSATION BOARD

Return of Earnings Statement

EMPLOYER IDENTIFICATION & ASSESSMENT PERIOD

EMPLOYER NAME

POLICY / REGISTRATION NUMBER

TRADING NAME (IF DIFFERENT)

INDUSTRY / CLASSIFICATION CODE

PHYSICAL ADDRESS

ASSESSMENT PERIOD FROM

ASSESSMENT PERIOD TO

DECLARATION OF EARNINGS

Category of Worker / Earnings Type	Number of Employees	Total Gross Earnings
Permanent / Full-Time Employees		
Part-Time / Temporary Employees		
Directors / Executive Officers (Subject to statutory caps)		
Contractors / Subcontractors (Deemed Workers)		
Total Declared Earnings		

ESTIMATED EARNINGS FOR NEXT ASSESSMENT PERIOD

Estimated Period	Estimated Number of Employees	Estimated Total Earnings
Future Period		

DECLARATION AND SIGN-OFF

I hereby certify that the information provided in this Return of Earnings statement is true, accurate, and complete to the best of my knowledge, and matches the financial and payroll records of the organization. I understand that providing false or misleading information may result in penalties, reassessment of premiums, or legal action under the relevant Workers Compensation legislation.

AUTHORIZED SIGNATURE

DESIGNATION / TITLE

DATE

AUTHORIZED SIGNATORY NAME

CONTACT NUMBER

EMAIL ADDRESS