MSI B

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:

Company/Organization Name: ______________________________

Employee Occupation (Job Title): ______________________________

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

Hourly Salary: ________ Weekly Salary: ________

Company/Organization Owner Signature: ______________________________

Employee Information:

Employee Name: ______________________________
(First Name) (Last Name)

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

Medicare Number: ______________________________

Social Insurance Number: ______________________________

Home Telephone Number: ____________ Cell Number: ____________

Home 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)

As a participant of Mohawk Self Insurance Program, I hereby agree to abide by the conditions as stated in the Mohawk Self Insurance Policy. I acknowledge the the information given is correct and may be used for verification between Mohawk Council of Kahnawà:ke operations.

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