Federal Workers' Compensation Services

Subscriber Enrollment Form for iNICS Access

Action Required	Create ☐	Revoke ☐	Re-Assign ☐ Token Number

1. Subscriber information

Organization Type	ESDC ☐	External ☐ Organization Name	
Employment Status	Indeterminate ☐	Term ☐ Term End Date	Security Status

Surname	Initials	Given Name	Job Title
Telephone Number		Email Address	
Civic address	City	Province	Postal Code

National Injury Compensation Internet site
This Internet site has been created for employers subject to the ***Government Employees Compensation Act*** (GECA). This site contains sensitive and private information. To view or download claim cost information, you must agree to the disclaimer below. The home department will be required to notify Federal Workers' Compensation Service of the user's departure from the organization/role.

Disclaimer
As the information on the Internet site includes personal information, I am limited in my legal right to access, use and disclose this information. The information contained on this site is subject to the authority of the ***Government Employees Compensation Act*** **(GECA) and is protected under the** ***Department of Employment and Social Development Act*** **(DESDA) and the** ***Privacy Act*** and should only be used in the context for which it was collected: for the purpose of administering workers' compensation. Specifically, as supporting documentation for payment of workers' compensation to the Labour Program, for case management, to understand trends and problem areas within their organization and to guide their disability management practices.

☐ I agree to the disclaimer

Signature

Date

2. Authorization

Surname	Initials	Given Name	Job Title
Telephone Number		Email Address	

I authorize _____ to have access to the iNICS application for 'Protected B' data pertaining to workers' compensation. This is in accordance with his/her job requirement. I acknowledge that the access gives nation-wide information to the user and I will be responsible for requesting for revocation of access to Federal Workers' Compensation Service on this user's departure from the organization/role.

Signature

Date

3. Approval

Surname	Given Name	Job Title
Signature		Date

Please forward this completed form to NC-FWCS-SFIAT-CLAIMS-RECLAMATIONS-GD@hrsdc-rhdcc.gc.ca or by mail to the address below. Please note that Section 1 is to be completed and signed by the subscriber; Section 2 by the subscriber's supervisor and Section 3 will be completed by the Manager of the Federal Workers' Compensation Service – Claims Operations Unit.

Federal Workers' Compensation Service
Claims Operations Unit
165 Hôtel de ville Street
L911, Phase II
Gatineau, Québec, K1A 0J2

Toll free number:
1-855-535-7299