Saskatchewan Workers' Compensation Board

200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4205
Toll-free fax: 1.877.220.1671
Email: employerservices@wcbsask.com

ACF

Click on any field to start editing.

Reset Form

Employer Account Closure Form (ACF)

Please complete if your business has had a change in ownership, sold, closed or is no longer operating in Saskatchewan.

Section 1: Mailing address and business information

Business name: _____ Account number: _____

Business address: _____ City: _____ Prov: _____ Postal code: _____

Business phone number: _____ Cell number: _____

Email address: _____

Contact information (who may we contact for additional information?)

First name: _____ Last name: _____

Contact's address: _____ City: _____ Prov: _____ Postal code: _____

Business phone number: _____ Cell number: _____

Email address: _____

Section 2: Reason for completing this form

Effective date of change(mm/dd/yyyy): _____

Will you continue operation in Saskatchewan? ☐ Yes ☐ No

Please check at least one of the following reasons why the account is to be closed:

☐ Closed business

☐ Cancel personal coverage

☐ Sale - ☐ Share
☐ Full Asset
☐ Partial Asset

☐ Not employing workers or contractors

☐ Amalgamation/Restructure

☐ Bankruptcy/Consumer proposal _____
Trustee Name: _____
Address: _____
City/Prov./PC: _____
Email: _____

Purchaser information

Business name(after sale): _____ Purchaser's name: _____

Relationship to seller: Family member ☐ Spouse/Partner ☐ Business Partner ☐ No relationship ☐

Purchaser's address: _____ City: _____ Prov: _____ Postal code: _____

Contact name: _____ Contact phone number: _____

Email address: _____

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Reset Form

Section 3 Workers' wages

Please include directors who receive T4 in actual wages.

Total gross earnings before deductions, per worker per calendar year (up to the maximum) 2017 maximum $76,086 2018 maximum $82,627

Year	Industry code	Description	Actual wages	Estimated wages

Section 4: Optional personal coverage

Please list who you would like to cancel or continue Personal Coverage for.

Industry code	Name(s)	Coverage amount	Continue Coverage	Cancel Coverage
			☐	☐
			☐	☐

Section 5: Contractors to be reported

Contract year	Name of contractor and address	Description of work	Total contract amount (exclude GST/PST)	Labour portion (if known)

Section 6: Additional information

Section 7: Declaration

READ CAREFULLY

By submitting this form, I certify and declare the following: that all the information provided is true, complete, and correct to the best of my knowledge; I am authorized by, and on behalf of, the business to make this declaration; I fully understand the content, the requirements of the submission, and that the WCB will use and rely on this information in the management of our business account; I understand this declaration; and that I or the business may be committing an offence and may be liable to statutory penalty or criminal prosecution if I make any false statement, provide any false or misleading information, or omit to provide any relevant information.

Signature: _____ Name: (please print) _____

Date: _____ Position: _____

Phone number: _____ Email: _____