WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Business Discontinuation Form

Assessment Services Department, 5595 Fenwick Street, Suite 109, PO Box 1150, Halifax, NS B3J 2Y2
Tel: (902) 491-8324 Toll free in Canada: 1-877-211-9267 Fax: (902) 491-8326 E-mail: assess@wcb.gov.ns.ca

Please use this form to notify us of any changes in your business status. If you have more than one WCB account, you must complete a separate form for each Business Number. Please return the fully completed form by fax or mail at the number and address noted above. If you have any questions, please contact us.

Business Name (Please print.) _____ Business Number: (9 digits) _____ NW (4 digits) _____

Please check the appropriate box below and provide all required information for that section. Do not use this form if you wish to cancel your Special Protection account. In this case, please contact us directly.

☐ **My business is closing temporarily.** To process this request, you *must* enter the exact *close and start dates.* If you are unsure of the exact date your business will start operating again, please enter the date that you expect operations to begin. If you realize later that your business will not start on this date, you must notify us immediately with a new expected start date.

The date operations will close is: Day _____ Month _____ Year _____

The date operations will start again is: Day _____ Month _____ Year _____

☐ **My business is closing permanently**.

The closing date is: Day _____ Month _____ Year _____

☐ **My business was sold, or is in the process of being sold.**

The date of sale was/is: Day _____ Month _____ Year _____

Purchaser's Name: _____

Address: _____

Telephone: _____ Fax: _____

☐ **I wish to cancel my coverage because the number of workers in my business will be less than 3 for at least 12 consecutive months.** I understand coverage is in effect up to the date the WCB receives this notification, and I must report all assessable payroll up to this date.

Current number of active officers: _____

Current number of employees: _____

☐ **I wish to cancel my voluntary coverage.** I understand coverage is in effect up to the date the WCB receives this notification, and I must report all assessable payroll up to this date.

Name (Please print.) _____ Signature _____

Position _____ Telephone _____ Date _____

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