

APPLICATION FOR HEARING LOSS RESULTING FROM EXPOSURE TO LONG-TERM OCCUPATIONAL NOISE

Please answer all questions and complete this report in ink. Incomplete applications may have to be returned resulting in some delay in the processing of your claim. Please ensure that this report is signed and submitted by mail or fax.

LAST NAME (please print) Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/>		WorkSafeBC (WCB) claim number	
First name(s)		Current or most recent employer	
Mailing address		Mailing address	
Mailing address		City	Postal code
City	Postal code	Location	Type of business
Telephone number ()	Social insurance number	Date of birth Month Day Year	Worker's occupation
		Employer's telephone number ()	

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1. Please detail what you consider as being the cause of your hearing loss and reasons for your answers.	5. Have you ever had a hearing test? If YES, who gave you the test and when? YES <input type="checkbox"/> NO <input type="checkbox"/>
	6. Have you ever made a claim for occupational noise-induced hearing loss in another province? If YES, please provide the claim number and jurisdiction. YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Did you lose any time from work as a result of hearing loss? If YES, please provide reasons. YES <input type="checkbox"/> NO <input type="checkbox"/>	7. Have you ever received a pension from WorkSafeBC (WCB of BC)? If YES, please give a claim number. YES <input type="checkbox"/> NO <input type="checkbox"/>
	8. Are you a relative of your employer or a partner or principal in the firm? If YES, explain on reverse side. YES <input type="checkbox"/> NO <input type="checkbox"/>
	9. If self-employed now, or at some time in the past, please include your WorkSafeBC account number and details of your coverage.
3.(a) Date and time you last worked	3.(b) Retirement date
4. Have you consulted a physician or audiologist regarding your hearing loss? If YES, please indicate name and date of appointment(s). YES <input type="checkbox"/> NO <input type="checkbox"/>	

PLEASE READ CAREFULLY AND SIGN APPLICATION

"I declare all the information I have given on this report is true and correct and I elect to claim compensation for the above-mentioned hearing loss. I authorize WorkSafeBC (Workers' Compensation Board) and Workers' Compensation Appeal Tribunal to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners, medical insurers or hospitals, a copy of records pertaining to examination, treatment, history and employment of the undersigned. Further, I acknowledge that WorkSafeBC may disclose information from my claim to my employer for the purposes of appeal, or may disclose such information to others in accordance with the law, including the *Freedom of Information and Protection of Privacy Act*. I authorize WorkSafeBC to disclose information from my claim to the designated advocate of my union or similar association. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising WorkSafeBC."

Worker's signature	Date	Personal health number from your BC CareCard												
	Month Day Year													

ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS REPORT. Please see page 2 for telephone and fax numbers.

Worker's last name	First name	Middle initial	Social insurance number	WorkSafeBC (WCB) claim number
				Worker's personal health number from BC CareCard

Additional information

Visit our web site at **WorkSafeBC.com**.

Mailing address for application and all claims correspondence: **WorkSafeBC**
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Fax number: Local 604 233-9777 or toll-free within BC 1 888 922-8807.

Telephone information

Call Centre: 604 231-8888 or toll-free within BC 1 888 967-5377.

Hearing Loss Unit: 604 276-3134 or toll-free within BC 1 888 967-5377 (extension 3134).

Other assistance

The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. The Workers' Advisers have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone at:

- Richmond 604 713-0360 or toll-free 1 800 663-4261
- Victoria 250 952-4393 or toll-free 1 800 661-4066
- Kelowna 250 717-2096 or toll-free 1 **866** 881-1188

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.