



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

Please answer all questions and complete this report in **INK** and submit via **FAX** to WorkSafeBC at the number provided on page 2 of this form. Incomplete applications may have to be returned resulting in some delay in the processing of your claim.

Worker information		Customer care number	WorkSafeBC claim number
Worker last name		First name	Middle initial
Address line 1		Preferred first name	
Address line 2		City	Province/state
Phone number (please include area code)		Country (if not Canada)	Postal code/zip
E-mail address	Worker's occupation	Date of birth (yyyy-mm-dd)	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Business phone number (please include area code)	Business ext.	Social insurance number	Personal health number (BC CareCard)

Employer information

Employer organization name	Operating location code	Phone number (please include area code)	
Mailing address line 1	Type of business	City	
Mailing address line 2	Country (if not Canada)	Province/state	Postal code/zip

1. Approximately when were you first aware of problems with your hearing (yyyy/mm/dd)?	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"/>
1A. What happened? 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. Do you deduct business or equipment expenses from your employment income? If yes, please answer the following: Yes <input type="checkbox"/> No <input type="checkbox"/>
	9. Are you a relative of your employer or a partner or principal in the firm? If yes, please explain on reverse side. Yes <input type="checkbox"/> No <input type="checkbox"/>
3.(a) Date you last worked (yyyy-mm-dd)	10. Do you have an account with WorkSafeBC (POP) ? Yes <input type="checkbox"/> No <input type="checkbox"/>
Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	11. If yes, what is your account number?
3.(b) Retirement date (yyyy-mm-dd)	

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 (yyyy-mm-dd)
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(continued)

Worker last name	First name	Middle initial	WorkSafeBC claim number
Social insurance number		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.

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. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604 713-0360, toll-free 1 800 663-4261; Victoria 250 952-4393, toll-free 1 800 661-4066; Kelowna 250 717-2096, 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.