



# APPLICATION OF WORKER Asbestos-Related Disease

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

**CLAIMS CALL CENTRE**  
Phone 604 231-8888  
Toll-free 1 888 967-5377  
M-F, 8:00 a.m. to 4:30 p.m.

**FAX**  
**604 233-9777**  
Toll-free **1 888 922-8807**

**MAIL**  
WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

<b>Worker information</b>		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
Home phone number (please include area code)		Country (if not Canada)	Postal code/zip
Business phone (please include area code)	Business ext.	E-mail address	
Date of birth (yyyy-mm-dd)	Personal health number (BC CareCard)	Social insurance number	
Worker's occupation	Weight	Height	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
		Marital status Married <input type="checkbox"/> Single <input type="checkbox"/> Other <input type="checkbox"/>	

## Employer information

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

## Questions

1. Give date of diagnosis of asbestos-related disease (yyyy-mm-dd)	If you are retired or disabled, give the date you last worked (yyyy-mm-dd)
2. On what date did you first become a resident of BC?	
3. When were you first employed in BC, where you first had exposure to asbestos? (on pages 2 and 3 of this form, please give names and addresses of all employers, dates, duration, and type of work done with each)	
4. Do you deduct business or equipment expenses from your employment income? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what is your type of employment Hired on a contract basis <input type="checkbox"/> Partner or principal <input type="checkbox"/> Fisher <input type="checkbox"/>
5. Do you have an account with WorkSafeBC (POP)? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what is your account number?
6. Have you worked outside of BC? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, on pages 2 and 3 of this form, please give names and addresses of all employers, dates, duration, and type of work done with each.
7. Have you ever suffered from tuberculosis? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when?
8. Have you every previously made a claim with another Worker's Compensation Board or agency for an asbestos-related condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when and where?
9. Are you in receipt of or entitled to any military pension, workers' compensation, or other pension, insurance, or benefit? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what?
10. Please provide confirmation of your gross earnings in the last three years that you worked (T4s, income tax records, etc.)	
11. How much work time did you lose during the past three years and what was the cause? (Please use "Additional Information" on page 3 of this form if necessary.) Sickness or accident _____ weeks <input type="checkbox"/> Holiday _____ weeks <input type="checkbox"/> Lack of work _____ weeks <input type="checkbox"/>	





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Worker last name	First name	Middle initial	WorkSafeBC claim number
		Social insurance number	Personal health number from BC CareCard

12. Please give name and address of any family physician or specialist that has diagnosed or treated your asbestos-related or other respiratory condition		
13. Have you had a chest X-ray? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you had a CT scan of your chest? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when?
14. Smoking history: Have you ever smoked? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, at what age did you start?	If yes, when did you quit?
Are you still smoking? Yes <input type="checkbox"/> No <input type="checkbox"/>	How many packs of cigarettes did you or do you smoke per day on average?	Did you/do you smoke Pipe <input type="checkbox"/> Cigar <input type="checkbox"/>
15. When you worked with/near asbestos, did you wear any respiratory protection? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, what?

### Worker's employment history

Please list all employers and any military service duties from the time you left school. Show all job categories held and length of time in each. Start with your first employment and proceed to your most recent employment.

Employer's name, location, and province	Years (from/to)	Occupation	Type of machinery or equipment used



# APPLICATION OF WORKER Asbestos-Related Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number
		Social insurance number	Personal health number from BC CareCard

**Worker's employment history *(continued)***

Please list all employers and any military service duties from the time you left school. Show all job categories held and length of time in each. Start with your first employment and proceed to your most recent employment.

Employer's name, location, and province	Years (from/to)	Occupation	Type of machinery or equipment used

**Additional information**

**PLEASE READ CAREFULLY:** 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 injuries or disease. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

16. Worker signature	17. Date of report (yyyy-mm-dd)
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**Other assistance** — Visit our web site at [WorkSafeBC.com](http://WorkSafeBC.com)

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/](http://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.