Application for Resolution of a Claim – Hearing Loss
October 2016 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application for Resolution of a Claim – Hearing Loss

Claim No. _____

vs.

Plaintiff/Employee

Defendant/Employer (Business Name)

Social Security Number/ Green Card

Defendant/ Employer Mailing Address

Birth Date Gender

City/State/Postal Code

Plaintiff Mailing Address

Insurance Carrier

City/State/Postal Code

Insurance Carrier Mailing Address

☐ Outside United States

City/State/Postal Code

Country

Plaintiff's Phone Number

Occupation

Additional Defendants

Additional Defendant

Additional Defendant

Mailing Address

Mailing Address

City/State/Postal Code

City/State/Postal Code

Reason for Joinder:

Reason for Joinder:

I. Nature of Occupational Hearing Loss

1. Date and Place of last exposure or accident resulting in hearing loss:

Date of Last Exposure/Accident	Place of Exposure/Accident (City/State/Postal Code)

☐ Plaintiff states that he/she became affected by reason of an exposure/accident arising out of and in the course of his/her employment.

2. Describe the nature of the occupational Hearing Loss:

3. When and by what means did the plaintiff/employee give notice of occupational hearing loss to the employer?

4. Name and address of physician providing medical report:

5. Nature of work in which the plaintiff/employee was engaged at the time of the occupationl noise exposure:

6. Will an interpreter be needed for the formal hearing? (Yes/No) _____

   If yes, in which language? _____

7. Have you previously filed for or received workers' compensation benefits in Kentucky? (Yes / No) _____
   If yes, please provide the following information:

Claim Number	Date of Injury	Nature of Injury/Disease	Awards/Benefits

   If not a Kentucky claim, please provide the state in which you were awarded benefits: _____

8. Was there concurrent employment at the time of injury? (Yes / No) _____

9. Was the defendant/employer aware of your concurrent employement? (Yes / No) _____

10. Name and address of concurrent employer:

Concurrent Employer Name: _____

Concurrent Employer Address: _____

Concurrent Employer City: _____

Concurrent Employer State: _____ Postal Code _____

11. Has the plaintiff/employee returned to work? (Yes / No)

12. Name and address of current employer and description of job currently being performed:

Current Employer Name: _____

Current Employer Address: _____

Current Employer City: _____

Current Employer State: _____ Postal Code _____

13. **Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No)**

If yes, submit form SVC within 15 days after filing the Application for Resolution of Claim.

Attestations:

☐ I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

☐ Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 to be separately filed, are true.

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

_____ _____

This form prepared and submitted by | Relationship to injured worker

_____ _____

Submitter Phone Number | Submitter Email Address

Instructions for Completion of – <u>Application for Resolution of a Claim – Hearing Loss</u>

1. All sections of this form must be completed, and the following shall be filed within 15 days:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report describing and supporting the occupational disease
   e. Proof of Wages, including W-2's, paycheck stubs, etc.
   f. Social Security earnings record release form

2. All information must be typewritten

3. File the original of this form and sufficient copies for all named defendants with the **Department of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

4. If you have no telephone number, please list a number at which you may be contacted.

5. If you have questions, call 1-800-554-8601.

Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.