October 2016 Edition

Filed:

Application for Resolution of a Claim – Hearing Loss

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of a Claim – Hearing Loss
Claim No. _____

_____
Plaintiff/Employee

_____
Social Security Number/Green Card

_____
Birth Date Gender

_____
Mailing Address

_____
City/State/Postal Code

☐ Outside United States

_____
Country

_____
Occupation

vs.

_____
Defendant/Employer (business name)

_____
Mailing Address

_____
City/State/Postal Code

_____
Insurance Carrier

_____
Mailing Address

_____
City/State/Postal Code

_____
Additional Defendant Name

_____
Mailing Address

_____
City/State/Postal Code

Reason for Joinder:

_____

_____

_____
Additional Defendant Name

_____
Mailing Address

_____
City/State/Postal Code

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)

2. Describe the nature of the Occupational hearing loss:

   _____
   _____

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

   _____
   _____

4. Name and address of physician providing medical report: _____
   _____

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

   _____
   _____

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

   If yes, 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 the injury? (Yes / No) _____

9. Was the defendant/employer aware of your concurrent employment? (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/employee 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.

_____

Signature of Attorney for Plaintiff/Employee or Pro Se Plaintiff

Instructions for Completion of Application
for Resolution of a Claim – Hearing Loss

Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and the following forms shall be submitted within fifteen (15) days of filing of the Application for Resolution of a Claim – Hearing Loss:
   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 supporting the occupational disease
   e. Proof of Wages, including W-2's, paycheck stubs, etc.
   f. Social Security earnings record release form.

2. This form may be filed in combination with an Application for Resolution of a Claim – Injury if both benefits are sought. Information provided should be current through the date application is signed by plaintiff/employee.

3. All information must be typewritten.

4. 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.

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.