Application for Resolution of a Claim – Hearing Loss
February 2020 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application for Resolution of a Claim – Hearing Loss

Claim No. _____

_____	vs.	_____
Plaintiff		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		
_____		
Email Address		
_____		
Plaintiff's Phone Number		
_____		
Occupation		

Additional Parties

_____	_____
Additional Party	Additional Party
_____	_____
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 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 was engaged at the time of the occupational 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 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 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. Highest grade completed in school? _____

14. G.E.D. Awarded? ☐ Yes ☐ No

15. Professional or Vocational Degrees, Certificates, or Licenses:

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

If yes, submit form SVC with the Application for Resolution of Claim.

NOTICE

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.

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

_____

Plaintiff Signature