# Application for Resolution of a Claim – Hearing Loss

**KENTUCKY DEPARTMENT OF WORKERS’ CLAIMS**  
Application for Resolution of a Claim – Hearing Loss  
Claim No. _______________________

<table>
<thead>
<tr>
<th>Plaintiff/Employee</th>
<th>Defendant/Employer (business name)</th>
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<tbody>
<tr>
<td>Social Security Number/Green Card</td>
<td>Mailing Address</td>
</tr>
<tr>
<td>Birth Date Gender</td>
<td>City/State/Postal Code</td>
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<tr>
<td>Mailing Address</td>
<td>Insurance Carrier</td>
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<td>City/State/Postal Code</td>
<td>Mailing Address</td>
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<td>City/State/Postal Code</td>
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<tr>
<td>□ Outside United States</td>
<td>Additional Defendant Name</td>
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<td>Country</td>
<td>Mailing Address</td>
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<td></td>
<td>City/State/Postal Code</td>
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<tr>
<td>Occupation</td>
<td>Reason for Joinder:</td>
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<td>Additional Defendant Name</td>
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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:

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Date of Injury</th>
<th>Nature of Injury/Disease</th>
<th>Awards / Benefits</th>
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</table>

   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, 500 Mero Street, 3rd Floor, 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.