Workers Compensation and Injury Management Act 2023

NOISE INDUCED HEARING LOSS —
COMPENSATION CLAIM FORM

Worker

Name: ---

Address: ---

Date of birth: ---

Phone number: ---

Email address: ---

☐ Male ☐ Female ☐ Unspecified

Employer

Name: ---

Address: ---

ABN: ---

Contact person: ---

Phone number: ---

Email address: ---

Insurer (completed by the insurer)

Name: ---

Insurer claim number: ---

Previous accepted NIHL claims

Date of claim	Compensation paid
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Note: WorkCover WA will be able to assist if you are unsure about previous NIHL claims

Test results and NIHL Assessment

My NIHL as assessed by an ENT specialist is: --- %

I have **attached** my Audiological Test Report authorising my NIHL assessment to this claim form: ☐ Yes ☐ No

I have **attached** my NIHL Assessment Report to this claim form: ☐ Yes ☐ No

I have **attached** my Worker Noise Exposure, Employment History to this claim form: ☐ Yes ☐ No

Note: your NIHL claim **cannot proceed** without including your Audiological Test Report, Worker Noise Exposure and Employment History, and NIHL Assessment Report confirming NIHL.

Worker's declaration

I declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself are true both in substance and in fact to the best of my knowledge and belief.

Signed: --- Date: ---

Consent authority (to be signed at the option of the worker)

I authorise any authorised audiologists who performed an audiological test or any authorised ENT specialist who performed a noise induced hearing loss assessment to discuss the results of that test or assessment, in relation to my claim for workers compensation, with my employer and with their insurer.

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, investigators, and legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers Compensation and Injury Management Act 2023*. I have read all the information on this form regarding the consent authority, and I consent to the Insurer dealing with my personal information in the manner described.

Signed: ..... Date: .....

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE CLAIM FORM OR THE CONSENT AUTHORITY MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM