Document Code: S6W

RESET FORM

Application for Workers' Compensation Benefits

If you haven't already done so, inform your supervisor of your accident/injury or illness.

Learn more about workplace injury recovery at worksafenb.ca

IMPORTANT: SAVE THIS FORM TO YOUR COMPUTER OR NETWORK DRIVE AND COMPLETE THE FORM FROM THAT SAVED VERSION! Do not complete this form from an online browser.

This form should only be completed when you want to apply for WorkSafeNB benefits. **You DO NOT need to complete this form if you do not want to file a claim**. Workers have a one-year time limitation (from the date of accident/injury) to file an application for benefits (six months in case of death).

Choice of language for correspondence
☐ English
☐ French

☐ I sought medical treatment for a workplace injury or occupational illness and I want WorkSafeNB to make a decision on my claim for wage loss replacement and/or medical aid.

☐ I experienced a workplace injury or occupational illness but I did not seek medical treatment. I want my application filed for record purposes only. I understand a decision will not be made on this claim.

Your health and wellness is a priority. This means timely medical treatment and wage replacement benefits. We know waiting can be difficult. To help ensure you get a decision on your application as quickly as possible, it's important that you complete all sections in FULL. Your application will not be processed until **ALL required information** has been received.

1. Your information

Last name	First name	Occupation	
Street address			Apt. no.
Town/City		Postal code	Province
Phone number (cell)	Phone number (home)	Phone number (work/other)	Preferred time to call ☐ Morning ☐ Afternoon
Email address	Birth date (yyyy-mm-dd)	Sex ☐ M ☐ F	Medicare number / Social insurance number
Employer	Employer address (street or PO Box number)		
Town/City	Employer contact	Employer contact's phone number	

2. Injury or illness

What caused your injury or illness?

☐ It was caused by specific incident (date: , time: ☐ AM ☐ PM)

☐ It occurred over a period of time (date you first noticed symptoms:)

☐ It's a recurrence of previous workplace-related illness or injury (previous claim number:)

A recurrence is the return of an injury or illness in which you previously received WorkSafeNB benefits (treatment and/or wage replacement). It is not a new accident or injury – but a flare up or recurrence.

Have you missed time from work beyond the date of accident due to this injury or illness? ☐ Yes ☐ No

Body part(s) injured	Specify left, right or both if applicable ☐ Left ☐ Right ☐ Both

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Did the injury/illness happen on the employer's premises? ☐ Yes ☐ No

If no, where did the injury/illness happen? (ex: hotel restaurant, store parking lot)?

Did the injury/illness happen in New Brunswick? ☐ Yes ☐ No If no, in which province (or state)?

Describe the type of injury/illness (select all that apply):

- ☐ Fatality
- ☐ TPI (ex: PTSD, stress, anxiety)
- ☐ Cancer
- ☐ Occupational disease
- ☐ Heart / Stroke
- ☐ Repetitive work injury
- ☐ COVID-19
- ☐ Infectious disease
- ☐ Allergic reaction
- ☐ Respiratory / Breathing
- ☐ Fainted
- ☐ Hearing loss, sudden*
- ☐ Hernia
- ☐ Amputation (arm/leg)
- ☐ Amputation (finger/toe)
- ☐ Fracture (broken bone)
- ☐ STI (strain, sprain, bruise)
- ☐ Head injury
- ☐ Dislocation
- ☐ Laceration / Cut / Abrasion
- ☐ Burn
- ☐ Puncture wound
- ☐ Bite
- ☐ Eye injury
- ☐ Dental (teeth)
- ☐ Needlestick
- ☐ Other (please explain):

Did you seek medical attention from a health care professional (doctor, nurse, physiotherapist, etc.)? ☐ Yes ☐ No

Name of health care professional (doctor, nurse, physiotherapist, etc.):

Name of facility (hospital, clinic, etc.):

Date seen: Were you admitted into hospital overnight? ☐ Yes ☐ No

Describe the accident in much detail as possible (maximum 2,000 characters), including what may have contributed to your injury/ illness. If you need more space, please attach a separate document. If a recurrence, describe the circumstances of the flare-up.

Did the incident involve a motor vehicle accident?	☐ Yes	☐ No
Did the incident involve a slip and fall in a parking lot?	☐ Yes	☐ No
Did the incident occur on a client or customer's property?	☐ Yes	☐ No
Did the incident involve an animal (ex. bite)?	☐ Yes	☐ No

*For noise-induced hearing loss, please complete the Application for Benefits - Occupational Hearing Loss.

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3. Work function

Your employer is required to offer meaningful and productive modified duties or other suitable work that is safe and within your capabilities.

Did your employer offer modified work (change of duties/tasks, reduced hours, etc.)? ☐ Yes ☐ No ☐ Not applicable If yes, when:	Have you returned to work? ☐ Yes ☐ No If yes, when: ☐ Full time ☐ Part time / ☐ Full duties ☐ Modified duties

4. Hours of work, wage and banking information

Complete this section **only if you lost time and are applying for wage replacement benefits** because of your injury/illness.

You must provide **pay stubs for the four weeks immediately before stopping work** because of your injury or illness with your application. If you don't know how to get your pay stubs, contact your employer.

Last date worked	Did you get paid for the full day? ☐ Yes ☐ No If no, how many hours were you paid?	Have you returned temporarily to work? ☐ Yes ☐ No If yes, provide date(s):
Hire date:	Work frequency ☐ Permanent full-time ☐ Permanent part-time ☐ Seasonal ☐ Casual If seasonal or casual, start date: , expected end date:	

Work type

☐ Owner-operator

☐ Subcontractor

☐ Piece worker (paid by amount produced/ services completed)

☐ Doesn't apply

Do you work the same days every week? ☐ Yes ☐ No

If yes, indicate **number** of hours worked each day of the week (example: 7.5)

M	Tu	W	Th	F	Sa	Su

If no, **average number** of hours per day:

In no, **average number** of days per week:

When you complete your income tax return, do you claim your spouse as a dependent? ☐ Yes ☐ No

Have you received or applied for Employment Insurance (EI) benefits since going off work with this injury/illness? ☐ Yes ☐ No

Have you received any wage replacement (sick, vacation, etc.) from your employer beyond your date of injury or illness? ☐ Yes ☐ No

WorkSafeNB requires **banking information to issue payments for wage replacement, travel cost reimbursement, etc.** You can provide this by including or attaching a void cheque with this application or submitting the following information:

Branch number: (may also be called "transit" number)

Financial institution:

Account number: (usually 7 digits / may be more depending on bank)

You'll find the banking numbers needed on the bottom of your cheques. Alternatively, you may find the numbers by visiting your financial institution's website and viewing the "Direct Deposit" or "Pre-authorized Payment" tabs. (Naming conventions may vary.) Note: You do not need to provide banking information if you are submitting this form for information purposes only (not seeking medical treatment and/or wage replacement.)

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5. Declaration and consent

☐ I declare that all the information provided by me is true and correct to the best of my knowledge.

☐ I agree to notify WorkSafeNB immediately of any work-related income received while on workers' compensation benefits, regardless of the source, and of a return to work or any other change in circumstances that may affect this claim application.

☐ I consent and authorize WorkSafeNB to gather, use, release or disclose information from this claim, including medical and financial information, as authorized by law and in accordance with the *Personal Information Protection* and *Electronic Documents Act*, the *Right to Information and Protection of Privacy Act* and *the Personal Health Information Privacy and Access Act*. WorkSafeNB takes the protection of your privacy seriously. Read our Access to Privacy and Information statement.

☐ I consent to and agree that any health care provider may provide any medical information related to my workers' compensation claim to WorkSafeNB and may provide any information related to my ability to return to work to WorkSafeNB or my employer.

Are you applying for WorkSafeNB benefits within one year from your date of your injury or illness? ☐ Yes ☐ No

You must report any workplace accident/injury or illness to your employer as soon as possible.

Did you report your injury or illness to your employer? ☐ Yes ☐ No

If yes, date reported to employer:

Please indicate that you have provided the following information to your employer:

☐ Date and time of the accident ☐ Body part(s) injured

☐ Cause of injury ☐ Where the accident happened

☐ Medical treatment you received, if any (provide name of health care provider/hospital/clinic and date of visit)

Name	Signature*(worker or dependent)	Date

* Your employer does not sign this form. The employer files an *Employer Report of Injury or Illness*.

6. Confirmation and submission

Before submitting, have you:

☐ Completed all required sections in full?

☐ Attached/included pay stubs (if applying for wage replacement)?

☐ Attached/included a copy of a void cheque or provided banking numbers?

To submit your application by email, attach the completed document and state "Application for benefits" in the subject line, then send to app-dem@ws-ts.nb.ca.

WorkSafeNB reminds you that submitting documents through unsecure email networks increases privacy concerns. For more information, please read WorkSafeNB's Access to Privacy and Information statement.

Or, you can submit your *Application for Workers' Compensation Benefits* by mail or fax: WorkSafeNB, 1 Portland Street PO Box 160, Saint John, NB E2L 3X9. Fax toll-free: 1 888 629-4722

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Instruction

Hurt on the job? We're here to help!

No one likes being hurt. But, if it does happen, it's good to know you have a reliable and supportive team behind you. Help starts with your employer. If you haven't already done so, inform your supervisor, manager or other appropriate person at your workplace of your accident/injury or illness as soon as possible.

Submit this form when applying for WorkSafeNB benefits, such as wage replacement and/or medical treatment (physiotherapy, medication, etc.), due to a workplace injury or illness. You must complete this form and send it to WorkSafeNB within one year from the date of the accident/injury or illness.

IS YOUR INJURY OR ILLNESS RELATED TO HEARING LOSS? Occupational hearing loss claims require additional information to help WorkSafeNB determine if the hearing loss is applicable for coverage under New Brunswick's Workers' Compensation Act. If you are applying for benefits related to hearing loss, please complete the Application for Benefits - Occupational Hearing Loss instead of this form. Exception: If your hearing loss is a result of a specific event, such as an explosion, please continue to complete this *Application for Workers' Compensation Benefits* form.

Reporting your injury or illness as soon as possible is important. It helps ensure you get the help you need.

Your health and wellness is a priority. This means timely medical treatment and wage replacement support. We know waiting can be difficult. To help ensure you get a decision on your application as quickly as possible, it's important that you **complete all sections of the form in full**.

IMPORTANT: Save this form to your computer or network drive BEFORE you start! Not doing so could result in loss of information. If opening the form in a web browser, we recommend using Internet Explorer or Edge.

Please have ready:

- Medicare and social insurance numbers
- Employer contact name and phone number
- Details of the accident/injury or illness, including date it happened and location
- Name of your health care provider and date of visit, if you received medical treatment
- **Pay stubs** (or other similar proof of income) for the four weeks before stopping work, if applying for wage replacement
- Void cheque or banking information (account, branch and financial institution numbers)

Your application will not be processed **until ALL required information** has been received.

Keep yourself connected

Work is good. It provides social connection and a sense of purpose, leading to positive physical and mental wellness. Evidence shows it also leads to a speedier recovery. To support you in your recovery, your employer, health care providers and others will make every effort to keep you connected to your workplace.

- **Employers** must keep in touch with you throughout the recovery process to maintain connection to the workplace; offer meaningful and productive modified duties or other suitable work that is safe and within your capabilities; ensure supervisors and co-workers support you during recovery; and collaborate with all return-to-work partners. This applies to all employers in the province, regardless of size, industry or injury risk profile.

- **As an employee**, you must keep in touch with your employer and WorkSafeNB throughout the recovery process; work collaboratively with your employer as they strive to find suitable work that is safe and within your capabilities; and work collaboratively with WorkSafeNB, including supplying information as requested.

- **Medical practitioners** provide timely medical care; submit reports to WorkSafeNB; help set expectations; and facilitate return-to-work efforts through effective communication and collaboration with all parties in the return-to-work process.

- **WorkSafeNB** administers health care and wage replacement benefits; co-ordinates and monitors required health care and rehabilitation services; helps develop, manage and monitor return-to-work plans; and helps set expectations for workers and employers.

To learn more about the claims process, potential benefits available, and healthy and safe return to work, please go to worksafenb.ca/workers. If you have any questions, please contact us toll-free at **1 800 999-9775** (Monday to Friday, 8 a.m. to 4:30 p.m.).