WORKSAFE
TRAVAIL SÉCURITAIRE NB

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Form B - Election to Claim Compensation (Interjurisdictional) – Hearing Loss

Name:		Claim Number:
Street Address:		Telephone Number:
City:		Date of Birth:
Province:	Postal Code:	Social Insurance Number:

I, _____, suffer from hearing loss that may be the result of my employment in the following provinces/territories/states:

1. New Brunswick	4.
2.	5.
3.	6.

I must choose whether I will claim compensation under the *Workers' Compensation Act* of New Brunswick or under the law of one of the other provinces/territories/states listed above.

Having considered the matter, I elect to claim compensation for my hearing loss under the *Workers' Compensation Act* of _____.
(your choice of province/territory/state)

If my claim is accepted, I waive and forego any rights to compensation in any other jurisdiction and will not apply for or accept any benefits from any other jurisdiction unless authorized to do so by the board or commission I elected above.

If my claim is rejected by that board or commission, I may then apply for compensation benefits

Worker's Signature: _____ Date: _____

Please mail your completed form to:
WorkSafeNB
P.O. Box 160
Saint John, NB E2L 3X9

Or fax it toll-free to:
1 888 629-4722