

DAMAGED EYEGLASSES NON-PERSONAL INJURY

Note: This form is only to be used if no personal eye injury occurred.

WCB Claim Number
Social Insurance Number
Personal Health Number

Worker's (Surname)	(First Name)	(Initial)	Date of Birth (YYYY/MM/DD)	
Address (Street)	(City/Town)	(Province)	Postal Code	Telephone Number
Employer's Name	Telephone Number	Date of Accident (YYYY/MM/DD)	Time of Accident	
Address (Street)	(City/Town)	(Province)	Postal Code	Fax Number
Account Number	Industry	Does injured worker have personal coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Is injured worker a partner or director in this business? <input type="checkbox"/> Yes <input type="checkbox"/> No	

What Costs Will the WCB Consider When Repairing or Replacing Damaged Eyeglasses?

The WCB may pay for repair/replacement of damaged or destroyed eyeglasses to a similar kind and quality as the damaged eyewear. **Please submit by mail the original invoice for the repair/replacement of the damaged eyewear.** Normally the WCB will only replace the damaged or destroyed part of the eyeglasses. For example, if only the frame is broken, the WCB will cover the replacement of the frame, but not the lenses.

Are Your Damaged Eyeglasses Covered by WCB?

The Board may pay the cost of eyeglasses that are lost, damaged or destroyed as a result of a work accident.

1. Were you wearing your eyeglasses at the time of the accident? Yes No
If no, explain why you were not wearing your eyeglasses.

Accident Details

2. Were you working at the time of the accident? Yes No
Please describe what you were doing when your eyeglasses were damaged.

3. Did the accident occur on your employer's premises? Yes No
If no, where did the accident occur?

Note: If you have answered "No" to any of the above questions, you may not be eligible for coverage by the Workers' Compensation Board. An adjudicator will review your claim and contact you with a decision.

Worker (Surname)	(First Name)	(Initial)	Claim Number
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Please complete this section.

Please check (✓) the correct sections, Original Lenses were:

<input type="checkbox"/> Single	<input type="checkbox"/> Progressive	<input type="checkbox"/> Seiko	<input type="checkbox"/> Tinted or Photo-grey
<input type="checkbox"/> Bifocals	<input type="checkbox"/> Hi-Index	<input type="checkbox"/> Zeiss	<input type="checkbox"/> Antiglare Treated
<input type="checkbox"/> Trifocals	<input type="checkbox"/> Nikon	<input type="checkbox"/> Other (specify)	

Describe the extent of damage to eye wear by placing a check (✓) in the appropriate section

Area of Damage	Scratched	Pitted	Broken
Right Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frames	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected "Pitted" above, did the pitting occur over time? Please explain.

If cost of eyeglasses exceeds \$500.00, please obtain an itemized receipt for replacement.

Declaration and Consent of Worker

I declare the information on this Damaged Eyeglasses Report Non-Personal Injury is true and correct. I understand that:

- Criminal prosecution may result from any attempt on my part to collect benefits by providing false information.
- My employer may examine my claim file for the purpose of reviewing or appealing any decision made on my claim. My claim file may also be examined by anyone with a direct interest, as determined by the WCB, or a person or company I have authorized to review my claim file.

I consent to the WCB collecting any information it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source.

Worker's Signature	Date (YYYY/MM/DD)
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The following section must be completed by the Employer

Name of Employer Contact	
Date worker notified you of the accident (YYYY/MM/DD)	Time worker notified you of accident

Were the worker's actions at the time of injury for the purpose of your business? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were the actions part of the worker's regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are the above accident details provided by the worker in accordance with your understanding of the accident and reports you have received from the worker or any other person? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, please explain any differences in the accident details <hr/> <hr/>

Declaration and Consent of Employer

I declare that I have reviewed the information on this Damaged Eyeglasses Report Non-Personal Injury and the above information I have provided above is true and correct. I understand that criminal prosecution may result from any attempt on my part to facilitate the collection of benefits by providing false information.

Signature	Job Title	Telephone Number	Date (YYYY/MM/DD)
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(This form is all the reporting that is required for damaged eyeglasses with no personal eye injury. Completion of the Workers' Report of Accident (C-060) nor the Employer's Report of Accident (C-040) is not required.)