wcb Workers' Compensation Board – Alberta
Box 2415
Edmonton AB
T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

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

C697
DAMAGED EYEGLASSES NON-PERSONAL INJURY

				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
Occupation:					
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 a WCB personal coverage number? If Yes, provide number ☐ Yes ☐ No			
Is injured worker a partner or director in this business? ☐ Yes ☐ 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.

Complete all the information below (incomplete information may cause delays)

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

1. If you were not wearing your eyeglasses at the time of the accident, please provide an explanation as to why not.

_____

_____

_____

_____

Accident Details

2. Provide a detailed description of exactly what you were doing when your eyeglasses were damaged.

_____

_____

_____

3. Did the accident occur on your employer's premises? ☐ Yes ☐ No If not, were you required to be at a different location for your work?

_____

_____

_____

***Note**: Detailed information is required. If you have not provided clear details you may not meet eligibility for coverage by the Workers' Compensation Board. An adjudicator will review your claim and contact you with a decision.*

(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.)

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker (Surname)	(First Name)	(Initial)	Claim Number

Please complete this section.

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

☐ Single	☐ Progressive	☐ Seiko	☐ Tinted or Photo-grey
☐ Bifocals	☐ Hi-Index	☐ Zeiss	☐ Antiglare Treated
☐ Trifocals	☐ Nikon	☐ 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	☐	☐	☐
Left Lens	☐	☐	☐
Frames	☐	☐	☐

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

_____

_____

Please attach an itemized receipt for replacements eyeglasses.

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)*

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? ☐ Yes ☐ No

Were the actions part of the worker's regular duties? ☐ Yes ☐ 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?

☐ Yes ☐ No

If not, please explain any differences in the accident details or submit an additional letter with clarification.

_____

_____

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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