Worker's Claim for Compensation

Workers Rehabilitation and Compensation Act 1988

PLEASE READ INSTRUCTIONS CAREFULLY

✓ To complete this form either:
- Type your responses in the relevant fields and sign by typing your full name in the signature field. Saving a copy and forwarding via email or by printing a hard copy.
- Print the form and complete by hand. Use a ball point pen and print all answers clearly.

✓ The information provided on this form is important for the management of the injured worker's claim. All questions must be completed by all parties concerned.

✓ Personal information collected from you for workers compensation processes will be used by the WorkCover Tasmania Board for that purpose and may be used for other purposes permitted by the *Workers Rehabilitation and Compensation Act 1988* (the Act) and associated laws.

✓ Failure to provide this information may result in your claim not being processed or records not being properly maintained. Your personal information may be disclosed to contractors and agents of the WorkCover Tasmania Board, law enforcement agencies, courts and other public sector bodies or organisations authorised to collect it.

✓ This information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by you on request to the WorkCover Tasmania Board. You may be charged a fee for this service.

TO THE WORKER

- Complete **questions 1 to 35** if you had a work-related injury or condition that may or may not have resulted in time off work or any incurred costs.
- It is **important** for the effective management of your claim that you **fully and clearly describe** how your injury or condition occurred and what caused it. Provide all information relevant to the occurrence of your injury **(questions 12 to 22)**.
- The detailed description of your injury is analysed and coded for data processing into the computer system of your employer, your employer's insurer and WorkCover Tasmania. You will greatly help in this process if you clearly describe how your injury occurred. Follow these rules when describing how your injury happened:
  - Do not write 'Refer to Report' or 'See workers compensation medical certificate'. Fully describe your injury in the space provided. Your Injury Report and workers compensation medical certificate are kept only by your employer's insurer. They are not forwarded to WorkCover Tasmania. A description of your injury is critical to the analysis and processing of information provided in this claim form.
  - Do not use abbreviations, brand names or models of machinery or equipment. Instead, specify the actual name or type of the machinery or equipment. For example, do not write 'lifting FMTX caused back strain', write down 'lifting TV camera caused back strain' or instead of 'driving Kubota', say 'driving bobcat/excavator/bulldozer/tractor' (whichever is applicable).
  - Specify day, month and year when filling in dates, instead of indicating 'ongoing' for date of accident or writing only your year of birth.
- Attach your **Initial Workers Compensation Medical Certificate** (obtained from a medical practitioner) and any accounts related to your injury.
- Give the completed form and any attachments to **your employer as soon as you can.**
- You may ask someone else to help you if you cannot fill in this form yourself.
- Send Continuing/Final Workers Compensation Medical Certificates and accounts to your employer as soon as they are available.
- Contact your employer if you need help or information.
- Make sure you keep a copy of this form for your records.

TO THE EMPLOYER

- **Notify your insurer of the claim** either by phone, fax or e-mail **within three working days from receipt of this form (question 57)**. Failure to provide notice of the claim will preclude you from indemnity for weekly payments for the period that notice was not given to your insurer (see Section 36 of the Act).
- Complete the Employer's Details section of this form **(questions 36 to 66)**.
- Calculate the number of **full-time equivalent workers (FTE)**. The FTE of a full-time worker is equal to 1.0. The calculation of the number of FTE for part-time or casual workers is based on the proportion of hours worked divided by the number of full-time hours, resulting in a number in the range of 0 to 1.
- Calculate the **normal weekly earnings (NWE)** over the 12-month period ending at the start of the period of incapacity. NWE is calculated as the average earnings over the 12 months prior to the date of incapacity. Where the worker has been employed by the employer for 14 days or less prior to his/her incapacity, refer to Section 69(2) of the Act.
- Calculate the **normal weekly hours (NWH).** NWH are the average number of hours per week that the worker has been employed by the employer. Where the worker has been employed by the employer for 14 days or less prior to his/her incapacity, refer to Section 69B(2C) of the Act.
- Overtime/excess hours are not to be included in NWE or NWH unless all of the following criteria are met:
  - (a) overtime/excess hours were a condition of the worker's contract of employment;
  - (b) overtime/excess hours were worked in accordance with a regular and established pattern and in accordance with a roster;
  - (c) the pattern was substantially uniform; and
  - (d) the worker would have continued to work the overtime/excess hours if he/she had not been injured (see Sections 69B(2D) and 70(2)(ab) of the Act).
- Calculate the **ordinary time rate of pay per week**. This relates to the payment for the worker for the work in which, and the hours during which, he/she was engaged immediately before the period of incapacity (see Section 69 of the Act).
- Specify the **date your insurer was notified of the injury**. Employers must notify their insurer of injuries within three working days of becoming aware that a worker has suffered a workplace injury (see Section 143A(1) of the Act).
- Specify the **date the claim was lodged with your insurer**. This relates to the date that the claim form was forwarded to your insurer. **Employers must forward claim forms to their insurer within five working days of receipt from the worker** (see Section 36(1) of the Act).
- If the worker is unable to fill in the form, please arrange for it to be completed on his or her behalf. If the worker requires access to an interpreter, please contact the Translating and Interpreting Service on 131 450.
- Send this form, Initial Workers Compensation Medical Certificate and accounts to **your insurer**. **All claims for compensation**, **must be** forwarded to **your insurer**.
- Send Continuing/Final Workers Compensation Medical Certificates and accounts to your insurer as soon as they become available.
- Make sure you keep a copy of this form for your records.

Worker – Complete worker section and send to your employer. Keep a copy for your records

Employer – Complete employer section and send a copy to your insurer. Keep a copy for your records

Insurer - Keep a copy for your records

For information and assistance on all workers compensation and injury management matters, telephone: 1300 366 322 (cost of local call) OR (03) 6166 4600 (outside Tasmania)

January 2018

INJURED WORKER'S DETAILS

1 Title (Mr/Mrs/Miss/Ms)

2 Surname

3 Given names

4 Residential address

Postcode:

5 Postal address *(if different from residential)*

Postcode:

6 Daytime contact phone numbers

M | W | H

7 E-mail address

8 Date of birth ...../...../.....

9 Gender Male ☐ Female ☐

10 Country of birth Australia ☐ Overseas ☐

If overseas print country of birth *Office Use*

11 If you have difficulty understanding English, what is your preferred language? *Office Use*

Incident & Worker's Injury Details

12 Date and time injury or condition occurred ...../...../..... : ☐ am/pm ☐

If different, date injury or condition first noticed ...../...../.....

13 Describe how the injury or condition occurred *Office Use*

(i) Give the details of what happened, how it happened and what was involved, *e.g. knocked off ladder by tractor and tractor ran over legs; inhaling asbestos fibres when demolishing old buildings*	*Mech*
	Agency of Injury
	B/down Agency of Injury
(ii) What was/were the most serious type(s) of injury or disease caused by this occurrence? *e.g. burn; cut; fracture; hernia*	*Injury*
(iii) What part of the body was most seriously affected by this occurrence? *e.g. upper arm; left ankle; right eye; upper back*	*POB*

You must attach a workers compensation medical certificate to this claim

14 Address where injury or condition occurred?

Postcode:

15 If stopped work, what was the date and time? ...../...../..... : ☐ am/pm ☐

16 Date and time started work on the day or shift of the injury or condition occurring ...../...../..... : ☐ am/pm ☐

17 Where did your injury or condition occur?

- At work—working at normal workplace ☐
- At work—road traffic accident ☐
- At work—on break ☐
- At work—working away from normal workplace ☐
- At work – working from home ☐
- Away from work during recess period ☐
- Travelling to or from work ☐
- Commuting/journey (excluding travelling to or from work) ☐

18 Is your injury or condition solely due to this occurrence? No ☐ Yes ☐

If no, give details below

19 Name of medical practitioner who provided immediate treatment

20 Name of treating practice or hospital

21 If treated at a hospital, were you admitted as an inpatient? No ☐ Yes ☐

22 Did you have any other employment at the time your injury or condition occurred? No ☐ Yes ☐ *If yes, give details below*

Worker's Medical Authority

NOTE: You do not have to complete this Authority. However, not doing so may mean delays to your claim being finalised.

To any medical practitioner or other person who has treated me, or the Registrar of any hospital at which I have received treatment.

I, employed by

authorise any medical practitioner or any other person who has treated me or the Registrar of any hospital at which I have received treatment to give my employer, or his insurer, information about myself specific to this claim for workers compensation. A photocopy of this authority is to be considered as valid as the original.

23 Your signature

24 Date signed ...../...../.....

25 Name of primary treating medical practitioner *(providing primary medical care)*

26 Contact details of primary treating medical practitioner *(practice name)*

Worker's Declaration

The *Workers Rehabilitation and Compensation Act 1988* imposes heavy penalties for giving false or misleading information.

I declare that to the best of my knowledge and belief, all the information given in this form is true and correct in every particular.

27 Your signature

28 Date signed ...../...../.....

29 Witness to signature

Notification and Witnesses

30 Name of person notified

31 Date and time notified ...../...../..... : ☐ am/pm ☐

32 Your supervisor's name

33 Name of any witnesses to the occurrence

34 Date claim form and workers compensation medical certificate given to employer

claim form ...../...../.....

medical certificate ...../...../.....

Previous Claims

35 Have you made any claims before? No ☐ Yes ☐

If yes, give details below

EMPLOYER'S DETAILS

36 Employer's legal name, i.e. Registered Company Name, State Government Department, Partnership, Sole Trader's Name

e.g. J Citizen Pty Ltd, Department of Education

37 Australian Business Number (ABN)

38 Employer's address

Postcode:

39 Employer's trading name or Division in State Government Department

e.g. J Citizen's Laundromat, Primary Education

40 Industry of employer *e.g. dry-cleaning services, dental sevices*

41 Number of full-time equivalent workers *(see front page for explanation)*

Treatment and Return to Work Details

42 Does the worker's medical certificate indicate a need for rehabilitation? No ☐ Yes ☐

43 Have you been contacted by the worker's treating medical practitioner to discuss treatment and/or return to work options? No ☐ Yes ☐

44 Can suitable duties be provided? No ☐ Yes ☐

45 What is the worker's estimated time off work? No lost time ☐

Lost time days

An Injury Management Co-ordinator is required to be appointed where incapacity (partial or total) exceeds 5 days. Return to Work and Injury Management Plans may be required and should be developed in accordance with time frames specified in insurer/employer Injury Management Programs approved by the WorkCover Tasmania Board. You should liaise with your insurer.

Worker's Employment Details

46 Normal weekly earnings *(see front page for explanation)* $

47 Ordinary time rate of pay per week *(see front page for explanation)* $

48 Normal weekly hours *(see front page for explanation)* (hrs)..... (mins).....

49 Average days usually worked per week

50 Worker's occupation at time injury or condition occurred *Office Use*

51 Department or section where injury or condition occurred *e.g dispatch, warehouse, sales* *Office Use*

52 Date the worker started in your employment ...../...../.....

Office Use

53 Is the worker a:

Direct employee ☐ Sub contractor ☐
Working director ☐ Labour hire worker ☐
Contractor ☐ Apprentice/trainee ☐
Worker of contractor ☐ Other ☐

If 'other' give details below e.g. in training program, police volunteer, fire fighting/fire prevention operations

54 Is the worker a:

Permanent employee ☐ Temporary employee ☐
Casual employee ☐ Temporary overseas visa worker ☐

55 If applicable, is the worker: Full-time ☐ Part-time ☐

56 Date insurer notified of injury *(see front page for explanation)* ...../...../.....

57 Date insurer notified of claim *(see front page for explanation)* ...../...../.....

58 Date claim lodged with insurer *(see front page for explanation)* ...../...../.....

59 Date of next payday following the date of claim receipt ...../...../.....

Employer Contact Information

Please give the name of someone who can be contacted for additional information about this claim

60 Contact name

61 Position

62 Contact phone

Employer Certification

The Workers Rehabilitation and Compensation law imposes heavy penalties for giving false or misleading information.

I am satisfied that the information given on this form is true and correct ☐

I believe that further investigation into this claim is required ☐

63 Employer representative's signature

64 Date signed ...../...../.....

65 Name of representative

66 Position

INSURER'S DETAILS

Policy and Claim Details

67 Insurer name *Office Use*

68 Policy number

69 ANZSIC classification of policy

70 Claim number

71 Claim type

New ☐ Re-opened ☐ If re-opened tick below

Aggravation ☐ Recurrence ☐ Other ☐

If 'other' give details below

72 Date claim received by insurer ...../...../.....

(For self-insurers this date will be the same as shown in question 58)