GOVERNMENT OF WESTERN AUSTRALIA

WorkCoverWA

WORKPLACE FATALITY COMPENSATION CLAIM FORM

Please see the attached Guidelines for Claimants for important information about completing this form.

1. CLAIMANT'S DETAILS

Given names:

Surname:

Date of birth: __ __ / __ __ / __ __ __ __

Occupation:

Mobile:

Phone:

Relationship to worker:

Residential address:

Email address:

Preferred language(s):
(if other than English)

2. WORKER'S DETAILS

Given names:

Surname:

Date of birth: __ __ / __ __ / __ __ __ __

Occupation:

Residential address prior to death:

3. EMPLOYER'S DETAILS

Employer's name:
(including trading name)

Employer's address:

Phone number:

4. DETAILS OF FATALITY

Date of injury: ☐☐ / ☐☐ / ☐☐☐☐ Date of death: ☐☐ / ☐☐ / ☐☐☐☐
(if different)

Was the death a result of the workplace injury? ☐ Yes ☐ No

Cause of death:

Worker's duties/tasks when injury/accident occurred:

5. COMPENSATION BEING CLAIMED

1. Death resulted from injury:

- ☐ Lump sum entitlement - *payable to dependant partner and/or children*
- ☐ Child's allowance - *payable for the benefit of each dependant child*
- ☐ Funeral expenses] - *payable to person who incurs expenses*
- ☐ Medical expenses]

2. Death did not result from injury:

- ☐ Lump sum entitlement - *payable to dependant partner and/or children*

6. DETAILS OF DEPENDANTS (Include any additional dependants on a separate page)

☐ *Documents attached to show dependency on earnings of worker at the time of death*

Dependant 1

Name: Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

Address:

Relationship to worker:

Contact number:

Dependant 2

Name: ____ Date of birth: __ __ / __ __ / __ __ __ __

Address: ____

Relationship to worker: ____

Contact number: ____

Dependant 3

Name: ____ Date of birth: __ __ / __ __ / __ __ __ __

Address: ____

Relationship to worker: ____

Contact number: ____

Dependant 4

Name: ____ Date of birth: __ __ / __ __ / __ __ __ __

Address: ____

Relationship to worker: ____

Contact number: ____

Dependant 5

Name: ____ Date of birth: __ __ / __ __ / __ __ __ __

Address: ____

Relationship to worker: ____

Contact number: ____

Do you know of any other person who is dependent on the earnings of the worker and may be entitled to make a separate claim?

If yes, please provide any details attached on a separate piece of paper.

☐ Yes ☐ No

7. CONSENT AUTHORITY

I hereby authorise any medical practitioner, medical practice or hospital to disclose to the worker's employer or the employer's insurer and WorkCover WA any information regarding the worker's medical history. However, I do not authorise the release or testing of human tissue samples or human tissue material of any kind or for any purpose.

Signature: ______________ Date: __ __ / __ __ / __ __ __ __

Name of worker's general practitioner: ______________

8. DECLARATION

Western Australia
Oaths, Affidavits and Statutory Declarations Act 2005
Statutory Declaration

I, ______________ (insert name and address) sincerely declare that all the information in the *Workplace Fatality Compensation Claim Form,* and any other attachment and supporting particulars are true and correct to the best of my knowledge.

To the best of my knowledge I have not omitted any information that may be relevant to my claim, including but not limited to the names of persons I believe may have been dependent on the earnings of the deceased worker.

This declaration is true and I know it is an offence to make a declaration knowing that it is false in a material particular.

This declaration is made under the *Oaths, Affidavits and Statutory Declarations Act 2005*.

at ______________
(place)

on __ __ / __ __ / __ __ __ __
(date)

by ______________
(signature of person making the declaration)

in the presence of

____
(signature of authorised witness)

____

____
(name and qualification of authorised witness)

INSURER TO COMPLETE

Name of insurer/self-insurer:	
WorkCover WA number:	
Claim number:	
Policy number:	