Form

Workers' compensation claim form

Part 1

To be filled in by **the worker**. The following information is provided as guidance to workers filling in **Part 1**.

Notify your employer of your injury or disease verbally or in writing, as soon as practicable.	☐
Fully complete Part 1, numbers 1 to 9, of the following claim form. The more information you provide on the form, the quicker the claim can be progressed. If there is not enough space on the form to include the relevant information, please use the space provided on the back page of this document. Claims should be made within 6 months, however, in some circumstances a claim can be made later. If you are unable to fill in this form and someone else does it for you, they must provide their details on the form at the end of Part 1 number 9.	☐
Sign the 'Workers authority to release medical and relevant personal information and declaration' located at number 9 on the claim form. The claim cannot be accepted without your signature.	☐
You must obtain a NT Workers Compensation 'Statement of Fitness for Work – First Certificate' from your treating doctor and submit it with your claim form if you are claiming compensation for loss of income.	☐
Keep a copy of your Workers' Compensation Claim Form and any documents you have attached for your own future reference.	☐
If you are claiming compensation for medical expenses only, you need to provide the relevant accounts or receipts with your claim form. You do not need to attach a 'Statement of Fitness for Work'.	☐
Deliver your claim form by hand or mail or email to your employer as soon as possible. If you are mailing the claim form then it is advisable to send it registered mail. If you are emailing the claim form then it is advisable to request a delivery receipt.	☐

What next

Once you have completed Part 1 of this form and given it to your employer, your employer must complete the employers report Part 2, numbers 10 to 14. Your employer has 3 working days to submit the claim to their insurer. The insurer has 10 working days after the employer received the claim from you, to make a decision and notify you. The possible decisions are:

- Accept liability for the claim
- Defer accepting liability for the claim
- Dispute liability for the claim

The insurer will advise you of your rights and entitlements for the different types of decisions. If this does not happen you can request that they do so, or contact NT WorkSafe for information.

Return to work

The purpose of workers compensation is to provide effective rehabilitation and economic support to injured workers. It allows for prompt and effective management of workplace injuries in a manner that promotes and assists the return to work of injured workers as soon as practicable and the effective rehabilitation of injured workers. You are required to cooperate with reasonable medical, surgical and rehabilitation treatment and you must participate in the return to work process.

The role of NT WorkSafe

The role of NT WorkSafe is to administer and enforce the *Return to Work Act*. NT WorkSafe provides a claims mediation service and will arrange a medical panel for disputed permanent impairment assessments. Claims are managed by approved insurers and self-insurers. NT WorkSafe has no legislative power to review claims decisions made by insurers. This power rests with the Work Health Court.

Disputes

Should you disagree with any decision made by the insurer regarding your workers compensation claim, please contact the insurer for information on their internal dispute resolution process or contact NT WorkSafe for information on mediation and dispute resolution procedures on 1800 250 713 or visit NT WorkSafe website.

Further information

Further information is available on the NT WorkSafe website, www.worksafe.nt.gov.au or by calling NT WorkSafe toll free number 1800 250 713 (Australia wide).

Part 2

To be filled in by **the employer.** The following information is provided as guidance to employers filling in **Part 2.**

Have you notified NT WorkSafe if the incident is a 'notifiable incident'. Failing to notify is an offence and penalties may apply, see **note 1** below.	☐
When you receive the claim form from your worker, you must complete Part 2, numbers 10 to 14 of the form.	☐
Check your worker has signed the 'Workers authority to release medical and relevant personal information and declaration' at number 9 of the claim form.	☐
Forward the claim form within 3 working days to your insurer, together with the NT Workers Compensation 'Statement of Fitness for Work – First Certificate' (if applicable) and any other attached documents. For example, medical receipts or accounts. If a decision as to liability for the claim is not made by the insurer within10 working days of you receiving the form, liability is deemed to be accepted. A claim may subsequently be disputed.	☐
Keep a copy of the claim form and attached documents for your own future reference.	☐
If the injured worker is unable to complete a claim form, please arrange for a claim form to be completed on their behalf.	☐
If a worker has died due to a work related injury or disease, do not fill in this claim form, instead please contact NT WorkSafe on our toll free number 1800 250 713 (Australia wide).	☐
If liability is accepted or deferred, and there is time lost, payments must commence to the worker within 3 working days of the decision. Your insurer will instruct you in this process. Subsequent payments should be made on a worker's normal pay day.	☐
Send other medical certificates and accounts to your insurer as they become available.	☐

NT WorkSafe
NT WorkSafe does not have a claims management role and employers should liaise with their insurer for information about the claims process and the calculation of weekly compensation.

Insurers
Insurers will provide employers with all the information needed to meet their obligations.

Return to work
The purpose of workers compensation is to provide effective rehabilitation and economic support to injured workers and provides for prompt and effective management of workplace injuries in a manner that promotes and assists the return to work of injured workers as soon as practicable.

The employer must take all reasonable steps to provide the injured worker with suitable employment, and when necessary, so far as is practicable, participate in efforts to retrain the worker. Refer to 'Rehabilitation – A Guide for Employers' available on the NT WorkSafe website.

If the employer is unable to provide the worker with suitable employment then the employer, in consultation with the insurer, must refer the worker to the alternative employer incentive scheme. Refer to information bulletin 'Alternative Employer Incentive Scheme' available on the NT WorkSafe website.

Further information
Further information is available on the NT WorkSafe website, www.worksafe.nt.gov.au or by calling NT WorkSafe toll free number 1800 250 713 (Australia wide).

Explanatory Note 1 for employers competing this form

Note 1 (number 10 of the claim form)
The *Work Health and Safety (National Uniform Legislation) Act* (WHS Act) requires the regulator (NT WorkSafe) to be notified of certain 'notifiable incidents'. In summary Part 3 of the WHS Act requires:

- Immediate notification of a 'notifiable incident' to the regulator after becoming aware of it by calling 1800 019 115 (this number can be used 24 hours a day)
- If the regulator asks, written notification must be given within 48 hours of the request. This must be provided in the approved '*Incident Notification Form*' available on the NT WorkSafe website.
- Preservation of the incident site until an inspector arrives or directs otherwise. This is subject to some exceptions.

Failing to notify is a criminal offence and penalties apply. Further information on what is a notifiable incident can be found in information bulletin 'Notification of Incidents' available on the NT WorkSafe website.

NT Workers' Compensation Claim Form

Section 82(1)(a) and 168(1)(a) of the Return to Work Act requires a claim for compensation be in a form approved by the Authority. This is the approved form for a Workers Compensation Claim, other than death. There is a separate approved form for death claim by dependents.

Insurer Claim No	This panel must be completed by the insurer	Work Health Authority Claim No
	Date claim form received:	
	Date worker notified:	
	Accept ☐ Deny ☐ Defer ☐	
	Reason:	

Worker to fill in Part 1, numbers 1 to 9 and then give to their employer to complete Part 2 numbers 10 to 14

Part 1 – Workers report on injury or disease

1. Worker details

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Last, surname, family name:

First or given name:

Other names you have been known by: (for example maiden name)

Gender: Male ☐ Female ☐ Date of birth: Age:

Home address:

Suburb: State: Postcode:

Postal address:

Suburb: State: Postcode:

Home number: Mobile number:

Work number: Email address:

Country of birth: Language spoken at home::

Marital status: Single ☐ Married ☐ De facto ☐

Dependants: Spouse: Yes ☐ No ☐ Children: Yes ☐ No ☐

Number of children: Dates of birth:

2. Workers job

Name of employer at time of injury or disease:

Your occupation and job title at time of injury or disease:

At the time of the injury I was working as a: Direct employee ☐ Working director ☐

Employee of contractor ☐ Contractor ☐ Sub contractor ☐

Visa worker ☐ Other (please specify)

Are you an apprentice or trainee: Yes ☐ No ☐

Are you: Full time ☐ Part time ☐ Permanent ☐ Temporary ☐ Casual ☐

Do you have other paid employment: Yes ☐ No ☐

If **yes**, give full name and address of employer: Name:

Address::

Suburb: State: Postcode:

3. About the claim

Where did the injury or disease occur: please cross

A.	At the workplace at which I am normally based	☐	B.	Working elsewhere	☐
C.	While I was having a break	☐	D.	Travelling to or from work	☐
F.	Attending training school	☐	J.	Travelling whilst on duty	☐

Other: give details

Exact location or address the injury or disease occurred:

When did injury or knowledge of the disease first occur:

Date: Time: am ☐ pm ☐

NT Workers' Compensation Claim Form

Part 1 – Workers report on injury or disease *continued*

4. About the incident

What were you doing at the time - how did the injury happen or what caused the disease. Include any object or substances involved. For example grinder, saw or drill. **Note**: if insufficient space, use the space provided on the back page of this form.

5. About the injury or disease

Part of body affected:	
Type of injury or disease: for example fracture, burn	
If more than one injury which is the most serious:	

6. Witness

Name and contact details of any person who was present at the time of injury:

Person name:					
Address:					
Suburb:		State:		Postcode:	
Home number:		Mobile number:			
Work number:		Email address:			

7. Other information

Did you report the injury or disease to your employer:		Yes ☐		No ☐	
If **no**, reason not reported:					
If **yes**:	Date		Time	am ☐	pm ☐
Name of person reported to:					
Persons position in the company:					
Did you stop work because of your injury or disease:		Yes ☐		No ☐	
If **yes**:	Date		Time	am ☐	pm ☐
Time you started work that shift:			Time	am ☐	pm ☐
If you stopped work have you started back at work:		Yes ☐		No ☐	
If **yes**:	Date				
Did you receive any medical treatment following your injury or disease:				Yes ☐	No ☐

If **yes**, give full name and address of treating professional:

Professional name:					
Address:					
Suburb:		State:		Postcode:	
Dates you were treated:					
Were you admitted to hospital:		Yes ☐	No ☐		

If **yes**, give full name and address of hospital:

Hospital name:					
Address:					
Suburb:		State:		Postcode:	

NT Workers' Compensation Claim Form

Part 1 – Workers report on injury or disease *continued*

Are you still receiving treatment:	Yes ☐	No ☐			
If **yes**, give full name and address of person treating you:					
Person name:					
Address:					
Suburb:		State:		Postcode:	
What are you claiming for: (if claiming for time off work, you must provide an NT Statement of Fitness for Work – First Certificate)					
Time off work, other than the day of injury	Yes ☐	No ☐			
Medical expenses, surgical, rehabilitation, hospital	Yes ☐	No ☐			
Have you suffered a similar injury or disease before:	Yes ☐	No ☐			
If **yes**, give full name and address of previous treating professional:					
Professional name:					
Address:					
Suburb:		State:		Postcode:	
Type of injury or disease:		Date injury or disease occurred:			
Have you previously claimed workers compensation for the same or similar injury:	Yes ☐	No ☐			
When was the compensation claim made: (date)					
Employers name:		Name of insurer: (if know)			

8. Previous employer

Could the injury or disease described in this claim have occurred in previous employment:	Yes ☐	No ☐	
If **yes**, name of previous employer:			
Employer suburb or town:		Period of employment:	
Name of insurer: (if known)			

9. Workers authority to release medical and relevant personal information and declaration

This authorisation and declaration must be signed or your claim will not be considered by the insurer

I authorise and consent to any person who provides me with a medical or hospital service, if requested by my employer or their insurer or the employer or insurer's appointed service providers, for the disclosure and release of information regarding the service that is relevant to the injury or disease for which I have made a workers compensation claim.

This authorisation and consent extends to the collection, disclosure and release of any health and related personal information that is relevant to the injury or disease for which I have made a claim, by my employer or their insurer or the employer or insurer's appointed service providers, including the disclosure and release of such information to each other, and/or to one or more of the following: the Work Health Authority (NT WorkSafe), a legal practitioner, medical practitioner, investigator, accredited vocational rehabilitation provider, or any other person reasonably consulted by the employer or insurer for making a decision as to payment of the claim for compensation.

I consent to NT WorkSafe using the information collected in connection with my claim to fulfil its obligations under the *Return to Work Act* or for the purposes of research about workers compensation, workplace injury management and work health and safety.

I understand that if this claim results in my receiving weekly compensation payments, I am required to notify the party paying my benefits if I commence employment with some other person, and that failure to do so is an offence.

I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that making a misleading statement or giving a document that contains misleading information is an offence.

Name: (print)		Date:			
Signature:					
Date that claim form forwarded to employer:		Posted ☐	By hand ☐	Emailed ☐	
If you are completing this claim form for the injured or diseased person, give your name and address:					
Name:		Address:			
Suburb:		State:		Postcode:	

Now that you have completed Part 1 numbers 1 to 9, forward your claim form to your employer
If claiming for time off work, include the NT Statement of Fitness for Work – First Certificate

NT Workers' Compensation Claim Form

Within 3 days the employer must complete the following numbers 10 to 14 and forward to insurer

Part 2 – Employers report on injury or disease

10. Notifiable incident – see note 1 on page 2 at the front of this form

Is this injury or disease the result of an incident required to be notified to NT WorkSafe:		Yes ☐	No ☐
If **yes**, date of notification:		Reference number given by NT WorkSafe:	

11. Employer information

Business entity name:					
Business trading name: (if different from above)					
Australian Business number: (ABN)					
Australian Company Number: if applicable					
Address for correspondence:					
Suburb:		State:		Postcode:	
Work number:		Mobile number:			
Fax number:		Email address:			
Name of person who can be contacted in relation to this claim:					
Position in the business:		Date claim received from worker:			

12. Workers' compensation insurance policy information

What is your workers compensation insurers name:			
What is the policy number:		What is the expiry date on policy:	

13. About the injured or diseased worker

What was the workers gross weekly remuneration before the injury or disease:		$			
Does this gross weekly remuneration include allowances:		Yes ☐	No ☐		
If **yes**, please provide details below:					
How many hours does the worker normally work each week:		Hours			
Does the worker normally work overtime or shift work:		Yes ☐	No ☐		
Is the worker provided with benefits not paid by money or a credit for accommodation, meals or electricity:					
Yes ☐	No ☐	If **yes**, what is the market value to the worker:	$		
Is the worker a fly in fly out or drive in drive out worker:		Yes ☐	No ☐		
Where within your establishment does the worker normally work: (your answer here must tell us the actual section and address of the workplace location where the worker does the majority of his or her work. If the worker works at multiple locations, tell us where the worker is normally based)					
Section where worker normally works:					
Normally based location address:					
Suburb:		State:		Postcode:	

NT Workers' Compensation Claim Form

Part 2 – Employers report on injury or disease - *continued*

How many people are employed at this particular location: (at the normally based location address, at the present time)

1 to 4	☐	5 to 9	☐	10 to 19	☐	20 to 49	☐
50 to 99	☐	100 to 199	☐	200 to 499	☐	500 plus	☐

When was the worker first employed by you:

Is the worker a contractor: Yes ☐ No ☐

Is the worker temporarily in Australia on a visa: Yes ☐ No ☐

If **yes**, expiry date on visa:

Do you, the employer agree with the workers description of the incident: (see number 4) Yes ☐ No ☐

If **no**, give details below of any other circumstances that may assist the insurer in assessing this claim:

What is the type of industry at the establishment where the worker normally works: (you must state the main type of activity, business or service you provide in which the injured worker was involved. You do not put the actual occupation of a worker, for example, if you are a gold mining company and the injured worker is a driver, put down gold mining)

14. Declaration

I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that making a misleading statement or giving a document that contains misleading information is an offence.

Name: of person who has filled in Part 2 numbers 10 to 14

Signature: Date:

Position in the business::

Date that claim form forwarded to insurer: Posted ☐ By hand ☐ Emailed ☐

Now that you have completed Part 2 sections 10 to 14, forward the claim form and any supporting documents to your insurer

NT Workers' Compensation Claim Form

Additional information to workers compensation claim form

Part 1 – Workers report on injury or disease

Part 2 – Employers report on injury or disease