NSW GOVERNMENT WorkCover

Allianz
Agent for the NSW WorkCover Scheme
ABN: 83 564 379 108/002
GPO Box 5429 Sydney NSW 2001
Ph: 1300 130 664 Fx: 1300 130 665 (General)
Fx: 02 9390 6633 (Direct line to first report)

Claimant Name | Date of Injury / / | Claim no.

WORKERS COMPENSATION ACT 1987

PERMANENT IMPAIRMENT CLAIM

This form should be submitted to make a claim for workers compensation for permanent impairment.
Please complete this form in BLOCK letters and use a black or blue pen.
If further space is required, attached a separate page.
This claim can only be made where the maximum medical improvement has been reached ie. that condition has been medically stable for the past 3 months and further recovery or deterioration is not expected in the next 12 months

1 HAVE YOU PREVIOUSLY SUBMITTED A SEPARATE WORKERS COMPENSATION CLAIM FORM IN RESPECT TO THIS INJURY?

☐ Yes ☐ No

If No, a separate Workers Compensation Claim Form must be completed and submitted with this form.

2 WORKER'S DETAILS

Title | Family name

Given names

Street address

Suburb

State | Postcode

Date of birth

☐☐/☐☐/☐☐

3 INSURER DETAILS

Claim number, if known

Insurer

4 INJURY DETAILS

Do not complete if the claim relates to noise induced hearing loss. Go straight to section 6.

Date of injury

☐☐/☐☐/☐☐

Clarification of date of injury if required (for example where the injury is a disease of gradual process)

Body system affected by the injury is

Percentage whole person impairment claimed or percentage loss is ☐ %

5 PREVIOUS INJURY (IES) OR PRE-EXISTING CONDITIONS

Do not complete if the claim relates to noise induced hearing loss. Go straight to section 6

Are there any previous injury(ies) or pre-existing conditions to which any proportion of the impairment may be due?

☐ Yes ☐ No

If Yes, give details of any such previous injury(ies) or pre-existing conditions.

Is there any previous employment to which any proportion of the impairment may be due?

☐ Yes ☐ No

If Yes, give details of such employment. Include employer's name, address, occupation period of employment and if a compensation claim was made.

Have you received any lump sum workers compensation for your impairment due to your current or previous employment?

☐ Yes ☐ No

If Yes, give details of workers compensation received. Include the date of injury, body system/part, % whole person impairment or loss, insurer, claim number and amount of compensation received.

6 HEARING LOSS CLAIMS

Complete if the claim is for noise induced hearing loss

Employers details. The employer to who notice of injury is given.

Business or company name

Street address

Suburb

State | Postcode

Claim no.

Business activity

If you are no longer employed by the above employer, what was your last day of employment with that employer?

/ /

Employment history - Occupation

Give details of work history in any noisy workplace in Australia or overseas over the five year period preceding this claim. You should include any work as an employee, in self employment, partnership, military service or otherwise. Even if you are unsure how noisy the work may have been, include these details. Provide details of the employer/business/other name, address, occupation and period of employment.

Have you been paid any compensation for loss of hearing in Australia or elsewhere?

☐ Yes ☐ No

If Yes, please give details

7 DOCUMENTS ATTACHED IN SUPPORT OF CLAIM

This claim must be supported by a medical report from a medical specialist.

- If the injury was sustained before 1 January 2002 the medical report must support the amount of loss claimed
- If the injury was sustained on or after 1 January 2002 the report must be form a specialist who is a WorkCover trained assessor of permanent impairment with qualifications, training and experience in a medical specialty relevant to the body system being assessed, This may be the worker's own treating specialist. The names of these specialists can be found on **www.workcover.nsw.gov.au**
- If the claim relates to hearing loss a copy of the audiogram used by the medical specialist in preparing the report must also be attached

List the document, author and date

8 DECLARATION

I, (PRINT NAME) have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading claim or a false or misleading statement in support of the claim is punishable by law and that if I make such a statement I may be prosecuted.

Signature of injured worker

Date

/ /

WC05226 0912 ISBN 978 1 74341 212 1