# Workers' Compensation Claim Form

**Workers – tear off and keep this section for your information**

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## Who can make a claim?

You are entitled to make a claim if you sustain an ***injury in the course of your employment*** **and are defined by law as a *worker***. The legal definition of a ***worker*** includes full-time, part-time, casual, seasonal, piece and commission workers. Working directors, contractors and sub-contractors may also be defined as workers depending on their working arrangements.

## How to claim:

Seek **first aid** and **report** the injury to your employer

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**See a doctor** of your choice as soon as possible and get a medical certificate. This is known as a *First Medical Certificate* in the workers' compensation system.

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Fill out the inside pages of **this form** and give it **and** your *First Medical Certificate* to your employer.

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Your employer must complete their part of the claim form and give it together with the *First Medical Certificate* to their insurer within **3 working days** of receiving the claim form.

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The insurer has **14 days** to assess the claim and can:

| Accept the claim | Dispute the claim | Pend the claim |
|---|---|---|
| ↓ | ↓ | ↓ |
| Your workers' compensation entitlements commence | No entitlements are made – you can dispute this decision | No entitlements are made – the insurer needs more time to make a decision |

## What happens if you don't agree with the insurer's decision?

Your employer's insurer has an internal dispute resolution process. You can approach the insurer to re-examine their decision.

In addition, the Dispute Resolution Directorate is an independent body that hears and determines disputes that may occur within the workers' compensation system.

To find out more about lodging an application with the Directorate or for general information about worker's compensation and injury management contact **WorkCover WA's Advisory Services on 1300 794 744.**

## How to make a claim with self-insurers

Some employers have been approved by WorkCover WA as self-insurers. This means that the employer covers the cost of its workers' compensation claims.

The process for making a workers' compensation claim is the same. However your **employer has 17 days** to assess your claim once they receive your completed claim form and *First Medical Certificate*.

You can ask your employer if they are a self-insurer. A list of self-insurers is available on the WorkCover WA website at www.workcover.wa.gov.au under Service Providers.

## What happens when my claim is pended?

An insurer can pend your claim if they need more time or more information to make a decision. They may contact you during this time for more information about your claim.

While your claim is being assessed, consider using any accrued leave (sick leave or annual leave) to provide you with interim financial support. If your claim is accepted, any leave you have used will be reinstated by your employer.

If a decision has not been made within **17 days** of you lodging your claim form and *First Medical Certificate* with your employer, you can apply to WorkCover WA for **interim compensation payments.** Contact Advisory Services on 1300 794 744 for more information.

WorkCover WA is the government agency responsible for overseeing the *Workers' Compensation and Injury Management Act 1981.*

## What does workers' compensation cover?

Once your claim is accepted you become entitled to workers' compensation payments. These may include:

- **wages** that should be paid on your normal pay day for any time that your doctor has certified you unfit for work
- **medical expenses** for hospital, medical and allied (eg physiotherapy) health treatment referred by your doctor and approved by the insurer. Your medical expenses are covered only up to a workers' compensation rate which is set by WorkCover WA. Be sure to check that your doctor charges this rate otherwise you may be left with a gap payment
- **rehabilitation expenses** to cover the cost of engaging an **approved workplace rehabilitation provider** to help your return to work
- **travel and accommodation** expenses in certain situations.

**Contact WorkCover WA for publications about your rights, responsibilities and entitlements.**

Wages, medical and rehabilitation payments are limited and subject to maximum amounts. You can call our Advisory Services staff on 1300 794 744 or visit www.workcover.wa.gov.au/Workers for further information.

While your claim is being assessed, you can ask your employer to pay you sick leave or annual leave you have already accrued. If your claim is accepted, you will receive your workers' compensation entitlements and your employer will reinstate your leave. **Remember you must have a medical certificate to cover any time you are away from work.**

## Know and understand your rights and responsibilities

**You:**

- have the right to **choose your own treating doctor** and **workplace rehabilitation provider**
- have the right to **claim lost wages from other jobs** if you have another job/s your injury prevents you doing
- have the responsibility to **attend certain medical appointments** at the request of your employer
- have the responsibility to fully participate in your **return to work program** once developed.

**Your employer:**

- has the right to **request a medical review** via your insurer before or after a claim has been accepted
- has the **right to discuss your return to work** with the treating doctor
- has the responsibility to have an **injury management system in place** and implement a **return to work program** when a doctor declares you fit for work in any capacity
- has the responsibility to keep **your original position available** for 12 months following a claim.

**Together:**

- you have the responsibility to fully participate with your treating doctor in developing an appropriate **return to work program.**

## Disclosure of Personal Information (consent authority)

Your employer's insurance company needs to collect, use and disclose personal information to assess, investigate and otherwise deal with your claim. **If you do not provide the information requested, this may affect the insurer's ability to assess your claim. This may cause significant delays in the claims process.**

By signing the *consent authority* on the Claim Form, you agree to the insurer:

a. collecting and using your personal information for the purpose of assessing, investigation and otherwise dealing with your current claim or any future claims.

b. disclosing personal information (on a confidential basis) to and collecting personal information from:

   - your employer, the insurer's entities, its investigators, auditors, medical service providers or any other party providing services to the insurer or any agent of these
   - other insurers, insurance intermediaries, government regulators or insurance reference bureau
   - lawyers and law enforcement agencies.

# Workers' Compensation Claim Form

## Insurer please complete

Insurer name
Claim number
ANZSIC Code
Policy number
WorkCover number
Has employer contacted medical practitioner? ☐ Y ☐ N

Estimated time off work:
- ☐ less than one day
- ☐ 1-4 work days (inclusive)
- ☐ 5-9 work days (inclusive)
- ☐ 10-20 work days (inclusive)
- ☐ more than 20 work days
- ☐ fatality

Date form received from employer

DATE STAMP

ASCO (office use only)

## Employer please complete

Name of policy holder/employer: _____
Trading as (if different to above): _____
Address: _____ Postcode: _____
Contact person name: _____ Phone No: _____ Email: _____
Address of injured worker's usual workplace or base: _____ Postcode: _____
Major activity of workplace (eg sheep farming, plumbing): _____
Date employer received the completed claim form from the injured worker: _____
Date employer received First Medical Certificate from the injured worker: _____
Date employer sent the claim form and medical certificate/s to insurer: _____

## Worker please complete

Surname:
Other names:
Address:
Suburb/City/Town: _____ Postcode: _____
Email:
Daytime contact phone no:
Occupation (eg first class welder)
Main tasks/duties performed (eg welding of high pressure steam pipes)

D.O.B. ☐ Male ☐ Female
Preferred language (if not English)

At the time of the injury I was working as a:
- ☐ direct employee
- ☐ sub contractor
- ☐ working director
- ☐ visa worker
- ☐ contractor
- ☐ other
- ☐ employee of contractor

If other, please specify:

☐ full time (F) ☐ part time (P) ☐ permanent (P) ☐ temporary (T) ☐ casual (C)

### Other Employment

**If more than one employer, please attach details on separate sheet**

Do you have any other job? ☐ Y ☐ N If yes, please give details:
Employer name: _____ Phone no: _____ Hours per week: _____

### Occurrence details

**Attach separate sheet if more space is required**

Day of occurrence: eg Monday | Date of occurrence: | Time of occurrence: ☐ AM ☐ PM

At what address did the occurrence happen?

Did you have to stop working? ☐ Y ☐ N If so when? Date: Time: ☐ AM ☐ PM

Were you:
- ☐ working – at your normal workplace
- ☐ on work break – at normal workplace
- ☐ working – away from normal workplace
- ☐ on work break – away from normal workplace
- ☐ working – road traffic accident commuting/journey
- ☐ other duty status

Describe the occurrence. Include:
(i) What action was involved (ie fall, struck by object)
(ii) What object/machine/substance was involved (ie fumes, door frame)
(iii) The most serious injury or disease caused (ie fracture, burn, abrasion)
(iv) The bodily location of the injury or disease (ie upper arm, eye)

| WorkCover WA Staff Only |
|---|
| Mechanism |
| Agency |
| Nature |
| Bodily location |

## Worker please complete

### Occurrence report – Describe how it happened

Attach separate sheet if more space is required

Where did the occurrence happen? (ie store room, machinery shop)

What were you doing at the time of the occurrence?

What were the normal working hours for that day? Starting time: ☐ AM ☐ PM | Finish time: ☐ AM ☐ PM

When did you first report the occurrence? Date: Time: ☐ AM ☐ PM

Who did you report the occurrence to?
Name: _____ Position: _____ Phone No: _____

If you didn't report the occurrence immediately, please state the reason if any:

Please provide the name and daytime contact phone number of witnesses of the occurrence:
1. Name: _____ Phone No: _____
2. Name: _____ Phone No: _____

### Medical help/history – this occurrence

Attach separate sheet if more space is required

When did you first seek medical attention? Date: Time: ☐ AM ☐ PM
If not immediately, please state the reason: _____

Was the part of the body affected by this occurrence healthy before this occurrence? ☐ Y ☐ N
If not, please give details: _____

Is the present injury completely related to this occurrence? ☐ Y ☐ N If not, please give details:

Please give details of any similar injury prior to this occurrence: _____

Name and contact details of your usual medical practitioner and any health provider who has treated you for a similar injury:
Name: _____ Address: _____ Phone no: _____

### Other/Previous claims

Attach separate sheet if more space is required

Are you claiming compensation from any other source? ☐ Y ☐ N If yes, from whom? _____

Have you had any similar or related workers' compensation claims? ☐ Y ☐ N If yes, please give details:

Name of Employer: _____ Address: _____
Name of insurer (if known): _____ Type of injury or disease: _____

### Worker's declaration

**I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.**

Dated this day of : _____ Year: _____

Signature of worker _____ Signature of witness _____

**Consent authority (to be signed at the option of the worker) I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.**

Dated this day of : _____ Year: _____

Signature of worker _____ Signature of witness _____

### Consent authority – to be signed at the option of the worker

**I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described.**

Signed _____ Witness signature _____

Print your name _____ Witness print name _____

Date _____ Date _____

**IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE CONSENT AUTHORITIES MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM**

## Checklist and handy hints

### For the Worker

- ☐ Complete the form with a ballpoint pen.
- ☐ If you need help completing the form, you can get your employer, a friend or family member to help you or you can call WorkCover WA on 1300 794 744. If required, an interpreter can also be arranged by WorkCover WA free of charge.
- ☐ The claim form is printed on carbonised paper which produces an exact copy on the sheet below it. Make sure you write on the centre sheets only and press firmly.
- ☐ Provide **all** the information requested. Give your full name, postal and email address and daytime contact phone number in case you need to be contacted.
- ☐ It may be helpful to attach a separate sheet to your claim form **if more space is needed** to provide information about your injury, how it happened and your medical history.
- ☐ Read and sign the ***worker's declaration*** and the ***consent authority (optional).***
- ☐ Attach the *First Medical Certificate* you received from your doctor to this claim form (your claim cannot be processed until both your claim form and *First Medical Certificate* are received).
- ☐ Keep records! Take a photocopy of your claim form and keep a record of the date you gave the claim form and medical certificate to your employer.
- ☐ Tear off the information section of this form and keep for your future reference.

### For the Employer

- ☐ **Tear off the information section of this form and give it to the injured worker.**
- ☐ Make sure the worker has completed all sections of the claim form. If they have difficulty completing it, let them know that they can seek help from you, or a family member or friend.
- ☐ Make sure you complete the employer details section.
- ☐ Review the *First Medical Certificate*. Has the doctor indicated that the worker has **capacity to work** in either their pre-injury job or in alternative duties? If so, you are required by law to **develop a return to work program.** Visit the WorkCover WA website www.workcover.wa.gov.au for further information and templates or contact your insurer for assistance.
- ☐ If the doctor has indicated that the worker will be off work for more than three days or can't return to normal duties, they will be expecting you to contact them.
- ☐ Keep records! Develop a case file, photocopy all relevant paperwork and keep it in a safe and private location and date all correspondence.
- ☐ Forward this form to your insurer within **three working days** of receiving it. Make sure you attach:
  - the worker's *First Medical Certificate* and any subsequent medical certificates
  - medical accounts (if any)
  - any other reports your insurer asks you to complete.
- ☐ If an injury is likely to prevent an employee from working for **10 consecutive days**, you **must also notify WorkSafe** on (08) 9327 8800. A list of reportable injuries and diseases can be found at: www.commerce.wa.gov.au/WorkSafe/ There are also reporting requirements for **all injuries in the mining sector.** Visit www.dmp.wa.gov.au for further details.

## Further information and assistance

WorkCover WA is the government agency responsible for overseeing the *Workers' Compensation and Injury Management Act 1981* (the Act) in Western Australia.

The role of WorkCover WA is to monitor compliance with the Act, inform and educate parties on all aspects of the workers' compensation and injury management system and provide an independent dispute resolution service.

If you would like further information about workers' compensation and injury management or information about seminars for injured workers contact:

**WorkCover WA**
2 Bedbrook Place
Shenton Park WA 6008

**Advisory Services 1300 794 744**
TTY (hearing impaired) (08) 9388 5537

**www.workcover.wa.gov.au**

**An interpreter service is available by arrangement with WorkCover WA**.

### Injury Management

Injury management is about managing workers' injuries in a manner that is **directed at enabling injured workers to return to work.**

Your employer should have a **written description of an injury management system** in your workplace and this should be made available to you if you ask for it.

**You should be involved with decisions regarding your return to work.**

It is important for you to:

- keep in touch with your employer, your doctor and other treatment providers
- submit medical certificates to your employer as soon as possible and on a regular basis to help keep your employer informed of your medical condition and level of fitness for work.

If your treating medical practitioner finds that you are partially fit to return to work in some capacity, a written return to work program will be established by your employer.

Workers should fully participate with their employer and medical practitioner in developing an appropriate return to work program. This will help develop a supportive environment that has the commitment of all parties to a successful return to work process. You have the responsibility to actively participate in your return to work program once developed.

**Make sure you have a say in determining your future at work by being involved in discussions that affect you.**

Publications for workers available from WorkCover WA:

- *Workers' Compensation and Injury Management: Important Information for Workers*
- *Understanding Workers' Compensation Entitlements*
- *A Guide to Resolving Disputes*
- *When do I need an Approved Medical Specialist? Information for Workers.*

**WorkCover WA also has a range of DVDs and fact sheets available to assist you to manage your claim.**