Toll Holdings Limited
ABN 25 006 592 089

Application for Compensation Form for Workers
Workers' Compensation and Rehabilitation Act 2003

IMPORTANT INFORMATION – PLEASE READ BEFORE SIGNING THIS FORM

The Application for Compensation Form for Workers is an approved form under Section 132 of the *Workers' Compensation and Rehabilitation Act 2003* (the Act). However, the information contained on this and the following page is not part of the approved form. This 'Important Information' is provided to assist you in completing this form and to give you an understanding of your rights and obligations under the Act.

WHO COMPLETES THE APPLICATION FOR COMPENSATION FORM FOR WORKERS

The injured worker must complete the Application for Compensation Form for Workers if they wish to apply for compensation.

If you are the injured worker and are unable to complete the form because of a physical or mental incapacity, another person may do so on your behalf (see Section 132(5) of the Act).

PROCEDURE FOR COMPLETING THE APPLICATION FOR COMPENSATION FORM FOR WORKERS

If you require assistance in completing the form please telephone **Toll Group Qld Self Insurance Unit** (07) 3275 0450.

You are required to complete the entire form. However, if any question is not applicable to your situation, please mark it "n/a" or "not applicable".

If there is insufficient space on this form to adequately answer questions, please attach additional pages.

WHAT DOES YOUR INSURER NEED TO ASSESS A CLAIM?

Toll Group Qld Self Insurance Unit needs the following documents to start assessing a claim:

A completed Application for Compensation Form for Workers.

An original Workers' Compensation Medical Certificate signed by the Doctor or registered dentist, who attended you or a Declaration if you have not seen a Doctor, must accompany this application form (see Section 132(3) and (4) of the Act).

HOW CLAIMS ARE ASSESSED?

Toll Group Qld Self Insurance Unit assess each claim on its merits. Although the majority of claims are determined in a timely manner, there may be occasions where **Toll Group Qld Self Insurance Unit** may require additional information.

YOUR ENTITLEMENTS TO COMPENSATION

Your entitlement to compensation arises on the day your injury is assessed by a doctor or dentist (see Section 141(1) of the Act). Your application for compensation is valid and enforceable only if it is lodged within 6 months after the entitlement to compensation arises (see Section 131(1) of the Act).

If your application is lodged more than 20 business days after your entitlement arises, **Toll Group Qld Self Insurance Unit** may only pay compensation for 20 business days before the day on which you lodged your application (see Section 131 of the Act.)

WHAT COMPENSATION IS PAID BY THE INSURER?

If a claim is accepted, **Toll Group Qld Self Insurance Unit** pays compensation such as weekly payments as income replacement and also medical, hospital and rehabilitation costs.

Employers have to pay their workers' wages for the day the injury happened. You should ask your employer who is responsible for paying your wages to make sure the payments you receive are correct.

GETTING BACK TO WORK QUICKLY AND SAFELY

Rehabilitation is the key to getting injured workers back to work quickly and safely. **Toll Group Qld Self Insurance Unit** requires both workers and employers to take active roles in rehabilitation, talk to your treating doctor or contact **Toll Group Qld Self Insurance Unit**.

It is a requirement of the Act that you satisfactorily participate in rehabilitation (see Section 232). If you fail to do so or refuse to participate without any reasonable excuse, **Toll Group Qld Self Insurance Unit** may suspend your entitlement to compensation.

ENGAGE IN A "CALLING"

You must notify **Toll Group Qld Self Insurance Unit** in writing within 10 business days if you engage in a calling or return to work of any kind or in any capacity (see Section 136 of the Act). You may do this by tendering a medical certificate which states that you are "fit to return" to work.

A "calling" means any activity, which usually results in the payment of wages, salary or reward. It includes self-employment or working at an occupation, trade, profession or carrying on a business, whether or not you receive wages, salary or reward (see Schedule 6 of the Act).

FALSE OR MISLEADING INFORMATION OR FRAUD

There are severe penalties for fraud or where there is any attempt to defraud Toll Group Qld Self Insurance Unit, or where false or misleading information if provided. For example by providing false or misleading information in an Application for Compensation Form for Workers.

RIGHT OF REVIEW OF DECISIONS

You have a right to have certain decisions reviewed by Q-COMP (see Section 540 of the Act). The decisions include a right of review of a decision by **Toll Group Qld Self Insurance Unit** to reject an application for compensation or a decision to suspend the entitlement for compensation because you failed to participate in rehabilitation as required, or otherwise to terminate, suspend, increase or decrease a weekly payment of compensation (see Chapter 13 Part 2 of the Act).

RIGHT OF APPEAL

You have a right to appeal a review decision (see Chapter 13 Part 3 of the Act). The appeal would be made to the Industrial Magistrate or the Industrial Commission and afterwards to the Industrial Court (see Chapter 13 Part 3 of the Act).

YOUR PRIVACY

Toll Group Qld Self Insurance Unit is authorised to collect the information in this form under s.132 of the Act.
The information collected on this form may be given to another person (eg a doctor) to assist with the determination or management of your claim or where it is required or authorised by law.

HOW TO LODGE FORM

To lodge your Application for Compensation Form for Workers: please mail your completed form along with the Workers' Compensation Medical Certificate to:

Toll Group Qld Self Insurance Unit

146 Kerry Road
ARCHERFIELD QLD 4108

PO Box 262
ARCHERFIELD QLD 4108

Phone: (07) 3275 0450 Fax: (07) 3275 7120

APPLICATION FOR COMPENSATION FORM FOR WORKERS ***Workers' Compensation and Rehabilitation Act 2003***

This Application for Compensation Form for Workers is an approved form for use under section 132 of the Workers' Compensation and Rehabilitation Act 2003. 132.TOLL

PLEASE COMPLETE THIS APPLICATION IN BLOCK LETTERS AND TICK BOXES WHERE APPLICABLE.

Claimant Details

1 Preferred Title
☐ Mr ☐Mrs ☐Ms ☐Dr ☐Other

2 Surname or family name

3 Former surname or family name (if applicable)

4 Given or first name

5 Gender
☐ Female ☐ Male

6 Date of Birth

7 Do you require an interpreter? If yes, which language?
☐ Female ☐ Male Language

8 Residential address
SUBURB/TOWN POST CODE

9 Postal address (is same as residential write "as above")
SUBURB/TOWN POST CODE

10 Email address

11 Work Phone

Home Phone

Mobile Phone

12 At the time of the injury, were you also working in another capacity of for someone else in addition to the employer listed in Q16. If so, please tick whether you were a:

☐ contractor ☐member of a partnership
☐ self-employed individual ☐a trustee

☐director of a corporation ☐ a volunteer
☐employed or self employed in any job other than the one in which the worker was injured

13 If question 12 has been completed, please state the name and address of the employers organisation

14 At the time of your injury were you:
(a) working temporarily in Queensland
☐ Yes (please attach details) ☐ No
(b) working for an interstate or overseas employer
☐ Yes (please attach details) ☐ No

15 Do you receive a benefit from Centrelink or other insurer?
☐ Yes (provide details) ☐ No

Employer Details

16 Full name of employer

Employers Trading Name (eg Smiths Mechanics)

Address
SUBURB/TOWN POST CODE

Telephone

Employment Details

17 What is your occupation? (please be specific eg farmhand)

18 How long have you been employed with your employer? (please state years and months)

19 At the time of the injury, what was the basis of your employment? (ie regular hours, part time, full time, casual employment, number of hours per week to etc to determine whether "worker")

Injury Details

20 What is the nature of the injury?

21 What part of the body is injured? (eg index finger)

22 Where was the injury sustained (eg Workshop, Smith St)

23 When did your injury occur?
DATE: / / TIME: AM/PM

24 Did the injury happen:
☐ before work ☐ late in shift
☐ after work ☐ during overtime
☐ early in the shift ☐ over a period of time
☐ recess ☐ unknown
☐ middle of shift

25 If the injury occurred on your way to or from work, please state your starting time (if on way to work) or finishing time (if on way home from work) for work that day:
TIME: AM/PM

26 When did you first notice symptoms?

27 How was the injury sustained?

28 What activity were you engaged in at the time of injury?

29 Was a motor vehicle(s) involved?

☐ Yes ☐ No

30 Details of registration numbers and owners of vehicles?

31 Did police attend the accident? (If yes, please supply details of the officer and branch)

☐ Yes ☐ No

32 Did an ambulance attend the accident? (If yes, please supply details of the officer and branch)

☐ Yes ☐ No

33 Names, addresses, telephone details of witness

34 Was the injury reported to your employer or your employers' representative?

☐ Yes ☐ No

Name
Position

Telephone Number

35 When was the injury reported?

Day Date Time am/pm

36 When and where did you receive First Aid/Medical treatment following the injury?

Date
Doctors/Medical providers name

Address

SUBURB/TOWN POST CODE

37 Did you receive medical treatment in a hospital?

☐ Yes ☐ No
☐ Public ☐ In-patient
☐ Other ☐ Private
☐ Outpatient ☐ Emergency Facility

38 Have you returned to work?

☐ Yes ☐ No

Day
Date
Time am/pm

39 In what capacity? (eg full time, part time, suitable duties)

40 Have you previously suffered a similar injury/condition (If so, please provide details)

41 Have you previously claimed worker's compensation for any similar injury or condition? (If so, please provide details)

Claimant's Statement

In completing this Application for Compensation Form for Workers, I acknowledge that I have read the Important Information section. I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading.

I hereby authorise any doctors, health authority, allied health provider, rehabilitation provider or other insurer to disclose to Toll Group Qld Self Insurance Unit any information regarding my medical history relevant to this claim. I agree to advise **Toll Group Qld Self Insurance Unit** if there is any change in my circumstances or if I become aware of any matter that would make the above information false or misleading. In particular, I will advise **Toll Group Qld Self Insurance Unit** upon the occurrence of any change in my employment status during the currency of this claim.

The Information contained in this Application for Compensation Form for Workers is true and not misleading.

Claimant's Signature

Date:

If the claimant is unable to sign this form, an agent for the claimant may do so on the claimant's behalf.

Agent of Claimant's Signature

Date:

Agent's Family name Agent's Given Name

Agent's Address

Suburb Post Code

Reason claimant's unable to sign