Workers Compensation Claim Form

Workers – Keep this section for your information

Who can make a claim?

You are entitled to make a claim if you suffer an injury from employment and are defined as a worker.

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 Certificate of Capacity.
This is known as a *First Certificate of Capacity* in the workers compensation system.

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

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Your employer must complete their part of the claim form and give it together with the *First Certificate of Capacity* to their insurer within **7 days** after receiving the claim form.

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The insurer must within **14 days** assess the claim and notify you of one of the following

Accept the claim	Not accept the claim	Defer making a decision
↓	↓	↓
Workers compensation entitlements are payable	No entitlements are payable – you can dispute this decision	No entitlements are payable unless liability decision notice not given in time

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, WorkCover WA provides assistance regarding resolving disputes.

To find out more about having a dispute resolved or for general information about workers compensation and injury management contact **WorkCover WA's Advice and Assistance line on 1300 794 744.**

WorkCover WA is the government agency responsible for overseeing the *Workers Compensation and Injury Management Act 2023.*

What happens when my claim is deferred?

An insurer or self-insurer can defer making a decision on your claim if they need more time to make a decision.

Insurers and self-insurers must give you either a **liability decision notice** or a **deferred decision notice** within 14 days after receipt of the claim. If neither of these notices are given within 14 days, liability is taken to be accepted.

If a liability decision notice cannot be given in 28 days after receipt of the claim, provisional payments will become payable.

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.

What does workers compensation cover?

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

- **Income compensation** for lost earnings that should be paid on your normal pay day for any period of time that your doctor has certified you unfit for work
- **medical and health related expenses** for hospital, medical and allied health (e.g. physiotherapy) treatment services that are reasonably necessary
- **workplace rehabilitation expenses** to cover the cost of engaging **an approved workplace rehabilitation provider** to help you return to work
- **travel and accommodation** expenses in certain situations.

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

Income compensation, medical and health expenses, and workplace rehabilitation payments are limited and subject to maximum amounts. You can call our Advice and Assistance staff on **1300 794 744** or visit **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 Certificate of Capacity 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 **privacy** while being examined or treated by your GP
- your employer, the employer's insurer or an agent of the insurer cannot be present during examination or treatment
- have the right to **claim lost earnings 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
- must, in cooperation with your employer, make reasonable efforts to return to work
- have the responsibility to participate and cooperate in the establishment of a **return to work** program and comply with any reasonable conditions under the program including any obligation to undertake workplace rehabilitation
- must comply with any requirement to attend a return to work case conference
- provide each progress certificate of capacity to your employer or employer's insurer within seven days (unless it is given by your treating doctor).

Your employer:

- has the right to **request a medical review** via their insurer after a claim has been made
- cannot be present while you are being examined or treated by your doctor
- has the **right to discuss your return to work** with the treating doctor in a return to work case conference
- has the responsibility to have an **injury management system in place** and implement a **return to work program** when required
- has the responsibility to keep **your pre-injury position available, if practicable,** for 12 months from when you were unfit for work
- cannot try and stop you from making a claim and must give your claim to the insurer.

Together:

- you have the responsibility to work with your treating doctor and cooperate to establish a **return to work program** when required.

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, but your consent must be obtained for this to occur.

By signing the *consent authority* on the Claim Form, you consent to the collection by, and disclosure to, persons named in the authority of your personal information that is relevant to your injury, claim or injury management.

If you do not provide consent by signing the *consent authority,* this may affect the insurer's ability to assess your claim and may cause delays in the claims process.

Workers Compensation and Injury Management Act 2023

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

ANZSCO (office use only)

Employer please complete

Name of policy holder/employer: _____ ABN: _____

Trading as (if different to above): _____

Address: _____ Postcode: _____

Contact person name: _____ Phone: _____ 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 sent the claim form and Certificate(s) of Capacity to insurer: _____

Worker please complete

Surname: _____

Other names: _____

Address: _____

Suburb/City/Town: _____ Postcode: _____

Email: _____

Daytime contact phone number: _____

Occupation
(eg first class welder) _____

Main tasks/duties performed (eg welding of high pressure steam pipes)

☐ full time (F) ☐ part time (P)

☐ permanent (P) ☐ temporary (T) ☐ casual (C)

Date of Birth: _____

☐ Male ☐ Female ☐ Unspecified

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: _____

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: _____ 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
- ☐ working from home
- ☐ 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 (i.e. fall, struck by object)

(ii) What object/machine/substance was involved (i.e. fumes, door frame)

(iii) The injury or disease caused (i.e. fracture, burn, abrasion)

(iv) The bodily location of the injury or disease (i.e. 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: _____

Concurrent claims

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

Worker's declaration

I 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 *Workers Compensation and Injury Management Act 2023,* I am required to notify my employer or insurer within 7 days if I commence paid work with another employer after making a claim, or while receiving income compensation.

Sign _____ Print your name _____

Date _____

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

I authorise any doctor who treats me 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.

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, workplace 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 2023*. 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.

Sign _____ Print your name _____

Date _____

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

Checklist and handy hints

For the Worker

- ☐ 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.
- ☐ 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 Certificate of Capacity* you received from your doctor to the claim form (your claim cannot be processed until both your claim form and *First Certificate of Capacity* are received).
- ☐ Keep records! Take a photocopy of your claim form and keep a record of the date you gave the claim form and Certificate of Capacity to your employer.
- ☐ Keep the information section of this form for your future reference.

For the Employer

- ☐ **Make a copy of the claim 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, a family member or friend.
- ☐ Make sure you complete the employer details section.
- ☐ Review the *First Certificate of Capacity.* Has the doctor indicated that the worker has some **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 **workcover.wa.gov.au** for further information and templates, or contact your insurer for assistance.
- ☐ You are encouraged to make contact with the worker if the doctor has indicated they are temporarily unfit for work or unable to return to normal duties.
- ☐ Keep records! Develop a case file, photocopy all relevant paperwork and keep it in a safe and private location and date all correspondence.
- ☐ Forward the claim form to your insurer within **seven days** of receiving it. Make sure you attach:
  - the worker's *First Certificate of Capacity* and any subsequent Certificates of Capacity
  - 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 the Department of Energy, Mines, Industry Regulation and Safety (www.demirs.wa.gov.au or 1300 307 877). In the mining industry, the Department must be notified on 1800 SAFE MINE (1800 723 364) or via the Safety Regulation System (SRS).

Further information and assistance

WorkCover WA is the government agency responsible for overseeing the *Workers Compensation and Injury Management Act 2023* (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, contact:

Advice & Assistance 1300 794 744

WorkCover WA 2 Bedbrook Place, Shenton Park WA 6008

Telephone interpreting

To use the telephone interpreting service:

- Step 1 - Telephone: 131 450
- Step 2 - Tell the operator the language you speak
- Step 3 - Tell the operator that you would like to speak to WorkCover WA on 1300 794 744.

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 Certificates of Capacity 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.

View our Return to work video on the WorkCover WA website at:
workcover.wa.gov.au/resources/educational-videos

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

Publications for workers, employers and insurers are available from WorkCover WA.