Form 275

Notice of claim for damages

Version 3

Workers' Compensation and Rehabilitation Act 2003 – Section 275
This is an approved form under section 275 of the *Workers' Compensation and Rehabilitation Act 2003*.

Insurer use only
Date of receipt of Notice of Claim for Damages:
Limitation date:
Damages claim No.:
Noted by:
Date:

Please note: If there is insufficient space on the form, you may attach separate sheets. If you attach separate sheets, clearly indicate the section number and the question number, and sign each separate sheet.

Section 1 – Non-compliance with section 275 and urgent proceedings under section 276 of the Act

1. State the reasons for the urgency and the need to start the proceeding:

2. Complete the following:

I, _____ ,
in reliance on section 276 of the *Workers' Compensation and Rehabilitation Act 2003* hereby request the workers' compensation insurer to waive compliance with the requirements of section 275. *(If you have completed this section, answer all following questions to the best of your ability and ensure that you or your lawyer sign* ***Section 6****.)*

Please note: The following information will assist the insurer in responding promptly. It should be noted, however, that providing this information is not a requirement under the *Workers' Compensation and Rehabilitation Act 2003*.

Date of injury *(dd/mm/yyyy) (for limitation period purposes)*:	DD / MM / YYYY

If the injury occurred over a period of time, provide reasons for the above date:

Section 2 – Claimant's/event details (whether claimant is worker or a dependent of a deceased worker)

3. Title: *(please select)*	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____		
4. Surname or family name:			
5. Given or first name/s:			
6. Gender:	☐ Male ☐ Female ☐ Other	**7. Date of birth** *(dd/mm/yyyy)*:	DD / MM / YYYY
8. Residential address of the claimant:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode		
9. Has the claimant ever been known by another name?			☐ Yes *(see below)* ☐ No
Surname or family name:			
Given or first name/s:			

Worker's details *(if worker different from claimant)*			
10. Title: *(please select)*	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____		
11. Surname or family name:			
12. Given or first name/s:			
13. Gender:	☐ Male ☐ Female ☐ Other	**14. Date of birth** *(dd/mm/yyyy)*:	DD / MM / YYYY
15. Residential address of worker at time of event:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode		
16. Has the worker ever been known by another name?			☐ Yes *(see below)* ☐ No
Surname or family name:			
Given or first name/s:			

Please note: if a **dependency** claim (i.e. the injury resulted in the worker's death), complete all relevant questions for each claimant from questions 17 to 33.

If claimant is the deceased worker's spouse	
17. Date of marriage *(dd/mm/yyyy)*:	DD / MM / YYYY
18. Place of marriage:	

(If you have completed this question, go to question 21.)

If claimant is the deceased worker's de facto	
19. Date on which de facto relationship started *(dd/mm/yyyy)*:	DD / MM / YYYY
20. Residential address where de facto relationship started:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode

If claimant is the deceased worker's spouse or de facto
21. Details of any health problems currently suffered by the claimant:

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22. Expected date of birth of any posthumous child/children of the relationship with the worker *(dd/mm/yyyy)*:	DD / MM / YYYY
23. Has claimant married, remarried or entered into a marriage-like relationship since the worker's death?	☐ Yes ☐ No
If **yes**, date of marriage *(dd/mm/yyyy)*:	DD / MM / YYYY
24. Was the claimant receiving an income before the worker's death?	☐ Yes ☐ No

If **yes**, give net *(after tax)* weekly income from all sources:

$	Source
$	
$	
$	
$	
$	
$	
$	
$	
$	

25. Was the claimant receiving an income after the worker's death?	☐ Yes ☐ No

If **yes**, give net *(after tax)* weekly income from all sources:

$	Source
$	
$	
$	
$	
$	
$	
$	
$	
$	

26. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount?	$

Method of calculation:

27. Did the deceased worker intend to continue working?	☐ Yes ☐ No
If **Yes**, to what age?	
28. Was the intended future employment full- or part-time?	☐ Full-time ☐ Part-time

(If claimant has completed this question, go to question 34.)

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If claimant is not the deceased worker's spouse or de facto	
29. Relationship to deceased worker:	

30. Details of any health problems currently suffered by the claimant:

31. What are the claimant's current net *(after tax)* weekly earnings?

$	Source
$	
$	
$	
$	
$	
$	
$	
$	
$	

32. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount?	$

Method of calculation:

33. Would the claimant have been dependent on the deceased worker?	☐ Yes ☐ No
If **yes**, to what age?	

Basis for dependency:

Worker's employment details at date of event	
34. Usual occupation:	☐ Full-time ☐ Part-time
35. Nature of employment at time of event *(if different from usual occupation)*	

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36. Details of every employer of the worker at the time of the event *(include details of self-employment)*:			
Trading name of employer:			
Business address:	Unit/Building no. Street no. Street name		
	Suburb/Town/Locality	State	Postcode
Trading name of employer:			
Business address:	Unit/Building no. Street no. Street name		
	Suburb/Town/Locality	State	Postcode

Details of the event resulting in the 'injury'			
37. Date and time of event *(dd/mm/yyyy)*:	DD / MM / YYYY	**Time:**	☐ am ☐ pm
38. If over period of time, state *(dd/mm/yyyy)*:	**when the period of the event commenced** DD / MM / YYYY	**when the period of the event ceased** DD / MM / YYYY	**when the symptoms commenced** DD / MM / YYYY
Date first seen by a health practitioner *(dd/mm/yyyy)*:	DD / MM / YYYY		
Health practitioner details			
Name:			
Address:	Street no. Street name		
	Suburb/Town/Locality	State	Postcode 5
Phone number:			
39. Where did the event happen? *(e.g. workshop floor, Smith Street, Bulimba)* **Please attach a diagram of the location** *(as relevant)*	Place		
	Street no. Street name		
	Suburb/Town/Locality	State	Postcode

40. Completely describe the details of the event resulting in the injury:

41. Details of employer's representative to whom injury was reported:			
Name:			
Position:			
Address:	Unit/Building no. Street no. Street name		
	Suburb/Town/Locality	State	Postcode

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Witnesses		
42. Was the event witnessed? *(provide details of all witnesses)*		☐ Yes ☐ No
Witness 1		
Surname or family name:		
Given or first name/s:		
Address:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode	
Phone number:		
Email address:		
What is the relationship, if any, of the witness to the worker?		
Witness 2		
Surname or family name:		
Given or first name/s:		
Address:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode	
Phone number:		
Email address:		
What is the relationship, if any, of the witness to the worker?		

43. Particulars of all injuries alleged to have been sustained because of the event *(For injuries occurring on or after 15 October 2013, a notice of assessment **must** be attached.)*

Part of the body injured (e.g. right index finger, lower back)	**Nature of injury/ies** (e.g. fracture, strain)	**Has a Notice of Assessment been received?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

WHSQ12286

44. List all doctors, hospitals, rehabilitation and any other service providers from whom the worker received treatment for the injury arising out of the event.	
Doctor/hospital name	Address

45. Has the worker sustained any personal injury/ies, illness/es, impairment/s or disability/ies of a medical, psychiatric or psychological nature, either before or since the event, that may affect the degree of permanent impairment resulting from the injury to which the claim relates or may affect the amount of damages in any other way?	☐ Yes *(complete table below)* ☐ No

Injury, illness or impairment	Doctor/hospital name	Address

46. Has the worker ever made a claim, either before or since the event, for damages, compensation or benefits as a result of any personal injury/ies, illness/es or impairment/s of a medical, psychiatric or psychological nature?	☐ Yes *(complete BOTH tables below)* ☐ No

Injury, illness or impairment	Name and address of insurer	Name and address of organisation or person against whom claim was made

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Injury, illness or impairment	Doctor/hospital name	Address

47. How is the worker presently affected by the injury/ies?
(e.g. symptoms suffered, effect at work and away from work including any impact on ability to work. If not affected, write 'nil'.)

Mitigation

48. Has the worker been provided with an assessment or provision of treatment or rehabilitation services? *(e.g. work training, counselling, independent living assistance, exercise program)*
Exclude details of any rehabilitation provided during the statutory claim as the insurer has this information.

☐ Yes *(complete table below)*
☐ No

Treatment	Name	Address

49. Provide particulars of all steps, other than rehabilitation, taken by the worker to mitigate loss including but not limited to search for work including listing all applications for employment made by the worker, consulting employment agency, re-training and any reasons why these steps were unsuccessful etc.

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50. Are you currently undertaking any paid or unpaid work with any employer or on a self-employed basis? If **yes**, please ensure all relevant details including name and address of income source *(e.g. employer*), any current period of employment/receipt of payment, capacity in which employed *(include self-employment or benefit details)* and gross and net *(after tax)* earnings for this period of employment are outlined in Section 3 - Income statement by worker.	☐ Yes ☐ No

51. Does the worker require any assistance with return to work or rehabilitation in relation to the injury/ies arising from the event and/or any other personal injury/ies, illness/es, impairment/s or disability/ies of a medical, psychiatric or psychological nature?	☐ Yes ☐ No
Please outline any specific assistance required:	

Section 3 – Income statement by worker

52. Provide details of employment, including self-employment and income details, for the three years before; for the period since the event resulting in injury; and at the date of signing the Notice of Claim. Any periods during which the claimant was in receipt of payments from the Department of Social Security or Centrelink must be shown. If there are periods of no income, state the periods, provide reason/s why no income was received and methods of financial support during these periods.

Name and address of income source *(e.g. employer)*	**Period of employment/receipt of payment**	**Occupation and capacity in which employed** *(include self-employment or benefit details)*	**Gross and net** *(after tax)* **earnings for each period of employment**

Section 4 – Liability

53. Did the worker cause, or contribute to, the event causing the injury?	☐ Yes ☐ No
54. To what extent of liability on the part of the worker, expressed as a percentage, does the claimant admit?	%

If the claimant cannot admit liability, provide reasons:

55. Provide the full particulars of any negligence alleged against the worker's employer:

56. To what extent of liability, expressed as a percentage, does the claimant hold the employer/s responsible?	%
57. Is negligence alleged other than against the worker's employer/s? *(If **yes**, complete below and questions 58–60)*	☐ Yes ☐ No

Name:				
Address:	Unit/Building no.	Street no.	Street name	
	Suburb/Town/Locality		State	Postcode

58. Provide the full particulars of any negligence alleged:

59. To what extent of liability, expressed as a percentage, does the claimant hold that party responsible?	%
60. If negligence is alleged other than against the worker's employer, has notice of the alleged negligence been given?	☐ Yes ☐ No

Party 1

If **Yes**, date notice given *(dd/mm/yyyy)*:	DD / MM / YYYY

Name and address of person to whom notice given:

Name:				
Address:	Unit/Building no.	Street no.	Street name	
	Suburb/Town/Locality		State	Postcode

WHSQ12286

Party 2	
If **yes**, date notice given *(dd/mm/yyyy)*:	DD / MM / YYYY
Name and address of person to whom notice given:	
Name:	
Address:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode

Section 5 – Amount and calculation of damages

61. Provide full particulars of the nature and extent of the amount of damages sought under each head of damage claimed and the method of calculating each amount.

NB. For injury/ies sustained on or after 1 July 2010, provide specific details of the dominant injury and the relevant injury scale value for the claimed injuries *(including any ISV uplift added to the injuries and PIRS rating for injuries of a psychiatric or psychological nature)*

Head of damage	Method of calculation	Amount ($)

WHSQ12286

Section 6 – Worker authority and declaration

I, _____

Name of claimant, address, suburb/town and postcode

declare under the *Workers' Compensation and Rehabilitation Act 2003* that all statements made in this Notice of Claim for Damages that are in my personal knowledge, are true, correct and complete in every respect.

I acknowledge that it is an offence under the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information I have provided is true and not misleading. I have not omitted any information which would make any of the above false or misleading.

I acknowledge my duty to mitigate loss and my obligation to satisfactorily participate in rehabilitation, any return to work program or suitable duties arranged or facilitated by the insurer under the *Workers' Compensation and Rehabilitation Act 2003*.

I agree to advise the insurer if my circumstances change or if I become aware of any matter that would make the above information false or misleading including any return to work (including any paid or unpaid work with any employer or on a self-employed basis).

I authorise any hospital, ambulance service of the state or another state, a doctor, provider of treatment or rehabilitation services or person qualified to assess cognitive, functional or vocational capacity or an employer, or previous employer or insurers that carry on the business of providing workers' compensation insurance, compulsory third party insurance, personal accident or illness insurance, insurance against the loss of income through disability, superannuation funds or any other type of insurance or a department, an educational and/or academic institution, agency or instrumentality of the Commonwealth or the State or a solicitor, to release any information or documents relevant to my claim for damages other than where giving information would breach legal professional privilege.

_____

Claimant's signature

Declared before me:

_____

Signature of Justice of the Peace or Commissioner for Declarations or Solicitor

Date DD / MM / YYYY _____ at _____ (place)

Justice of the Peace or Commissioner for Declarations or Solicitor (see below)	
Name:	
Address:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode
Telephone:	

Where a lawyer may sign: A lawyer may sign on behalf of the claimant **only** where there is an urgent need to commence proceedings AND where it is not reasonably practicable for the claimant to sign.

I, _____

legal representative of the claimant, _____

sign this Notice of Claim on behalf of the claimant because it is not reasonably practicable for the claimant to do so.

_____

Signature Date

Lawyer's contact details	
Name of firm:	
Address:	Unit/Building no. Street no. Street name Suburb/Town/Locality State Postcode
Telephone:	

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Privacy statement:

Under the *Workers' Compensation and Rehabilitation Act 2003* and earlier Queensland workers' compensation legislation, the workers' compensation insurer is authorised to collect the information on this form to process the notice of claim. Some or all of the information contained in this form may be disclosed to the claimant's employer, another insurer, medical or allied health providers or any other workers' compensation authority in any jurisdiction.

This form was approved by the Workers' Compensation Regulator, on 1 May 2014, pursuant to section 586 of the *Workers' Compensation and Rehabilitation Act 2003*.

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