Claim form

ReturnToWorkSA

The Return to Work scheme provides timely, personalised support and services to workers and their employers following a work injury.

South Australians who have been injured at work may be eligible for income support and/or the reimbursement of medical expenses and other return to work services.

Before making a claim workers need to

> notify their employer about the injury
> see a doctor to get a Work Capacity Certificate.

Call **13 18 55** as this form may not be required

How to make a claim using this form

Step 1 **Complete this form**

Wherever possible, the worker and the employer should complete this form together. A representative, such as a treating doctor, a worker's friend or a Return to Work Coordinator can assist the worker by completing information in the form with the worker's consent.

Step 2 **Sign the Medical Authority and declarations (page 4)**

Step 3 **Lodge this form**

South Australian businesses registered under the Return to Work scheme and their workers must ensure this completed and signed form and Work Capacity Certificate are sent to the employer's claims agent, either:

Employers Mutual SA
GPO Box 2575, Adelaide SA 5001
newclaims@eml.rtwsa.com
Fax (08) 8127 1200
www.employersmutual.com.au
Phone (08) 8127 1100 or 1800 688 825

OR

Gallagher Bassett Services Pty Ltd
GPO Box 1772, Adelaide SA 5001
newclaims@gb.rtwsa.com
Fax (08) 8177 8451
www.gallagherbassett.com.au
Phone (08) 8177 8450 or free call 1800 774 177

To find which is the employer's claims agent, use the Claims Agent Lookup at **www.rtwsa.com** or call **13 18 55**.

Self-Insured / Crown employers
Most of South Australia's largest private and public sector organisations are self-insured, managing their own workers compensation claims. Workers of self-insured businesses with a work injury should speak to their employer about making a claim.

Important information for workers

> Report a work injury to your employer as soon as possible and talk to them about a plan to stay at or return to work.
> Talk to your doctor about work tasks you can still do and obtain a Work Capacity Certificate.
> Be actively involved in your treatment, recovery and return to work, or stay at work plans.

Important information for employers

> Call your claims agent as soon as possible to report a work injury. Your claims agent will advise you immediately whether a Case Manager will be assigned. You may not be required to submit this form.
> If you do need to submit this form to your claims agent you must do so within five business days of receiving a claim from the worker.
> There are financial incentives for employers who make the claim and submit the Work Capacity Certificate (if you have been given one) within five calendar days of receiving the form from the worker. For more information on financial incentives visit www.rtwsa.com
> Notifiable incidents
It is a legal requirement under the Work Health and Safety Act 2012 for a person who conducts a business or undertaking to notify SafeWork SA of:

- the death of a person
- a serious injury or illness of a person including immediate treatment for amputation, serious head, eye, burn and laceration injuries, separation of skin from underlying tissue, spinal injury or loss of body function; medical treatment within 48 hours of exposure to substance
- a dangerous incident that exposes a worker or any other person to a serious risk to a person's health or safety emanating from an immediate or imminent exposure, whether or not an injury has actually occurred.

Please notify SafeWork SA by calling **1800 777 209**.

For more information about SafeWork SA please visit **www.safework.sa.gov.au**

Serious penalties could arise from failure to notify SafeWork SA of notifiable incidents. SafeWork SA receives ReturnToWorkSA claims data.

To contact ReturnToWorkSA in a language other than English call the Interpreting and Translating Centre (ITC) on 1800 280 203 and ask the consultant to organise a telephone interpreter in your language and to then be connected to ReturnToWorkSA on 13 18 55.

People with hearing / speech impairments can contact ReturnToWorkSA using the National Relay Service.

Need help?

If you have any questions about this form contact ReturnToWorkSA on

13 18 55 or
www.rtwsa.com

Government of South Australia

Section 1 - About this claim

1A - What is the claim for?

☐ Loss of wages ☐ Medical expenses

☐ Loss of wages and medical expenses

1B - Who is filling out this form?

When possible, it is suggested the worker and employer complete this form together.

☐ Worker ☐ Employer

☐ Both worker and employer completing the form together

☐ Other - Name: _____

Relationship (i.e. Family, friend or representative): _____

_____

Phone: _____

Section 2 - Worker details

Family name: _____

Given names: _____

Former names (if any): _____

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

Gender: ☐ M ☐ F ☐ Other

Address: _____

_____

Postal address (or if same write 'same as above'): _____

_____

Daytime phone number: _____

Mobile number: _____

Email: _____

(Note: Providing an email will ensure prompt receipt of important notices.)

Does the worker wish to identify as:

☐ Aboriginal ☐ Torres Strait Islander

Country of birth: _____

Does the worker need an interpreter?: ☐ Yes ☐ No

If yes, identify language (including Auslan): _____

Dialect: _____

Is the worker an Australian citizen or permanent resident of Australia?

☐ Yes ☐ No

If 'No': _____

Type of visa: _____

Expiry date: ☐☐ / ☐☐ / ☐☐☐☐

*Throughout this form 'injury' should be read as 'work related illness, condition or injury'

Section 3 - Injury details

3A - Injury information

What was the circumstance in which the injury occurred?

(tick one) while:

☐ Working at usual workplace

☐ Working, had a traffic accident—Police Report Number:

☐ Having a break ☐☐☐☐☐☐☐☐☐☐

☐ Travelling to or from work

☐ Attending an approved course of study

☐ Working elsewhere

☐ Other (please specify): _____

Date and time of the injury: (or when was it first noticed)

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Did the worker stop work due to the injury? ☐ Yes ☐ No

If yes, date and time work was stopped:

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Has the worker resumed work? ☐ Yes ☐ No

If yes, date and time worker resumed:

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Has the worker returned to:

☐ pre-injury hours or ☐ less than pre-injury hours

Has the worker returned to:

☐ normal duties or ☐ modified duties

3B - Where did the injury occur?

Place (e.g. workshop floor): _____

Address: _____

Suburb / town: _____ Postcode: _____

3C - Description of the injury

What is the injury and part of the body affected? (e.g. broken left lower leg, dermatitis of the hands, lower back strain): _____

_____

_____

What was the worker doing at the time of the injury? (e.g. lifting bags of cement from pallet to trolley): _____

_____

_____

_____

What happened and how was worker injured? (e.g. repeatedly lifting heavy bags causing lower back pain): _____

_____

_____

_____

_____

Section 4 - Capacity for work and treatment

4A - Treating doctor's information

Name: _____

Practice name: _____

Practice phone: _____

Practice address: _____

Suburb / town: _____ Postcode: _____

Hospital (if the worker was or is hospitalised): _____

4B - Work Capacity Certificate details

The worker's Work Capacity Certificate covers the period from:

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

Section 5 - Employment details

5A - Employer's name and address

Full company or business name: _____

Trading name: _____

Postal address: _____

Suburb / town: _____ Postcode: _____

Phone: _____

Email: _____

(Note: Providing an email address will ensure prompt receipt of important notices)

ReturnToWorkSA employer number: _____

ReturnToWorkSA location number: _____

Date worker started employment: ☐☐ / ☐☐ / ☐☐☐☐

Address of worker's usual workplace (if different from above):

_____

Suburb / town: _____ Postcode: _____

5B - Employer contact person for this claim

(e.g. Manager or Return to Work Coordinator)

Name: _____

Phone: _____

Position title: _____

Email: _____

5C - Employment type

Is the worker any of the following? (if not leave blank)

☐ an apprentice ☐ a trainee ☐ a working director

If the worker is not an employee what is the relationship?
(e.g, non-working director, sole contractor, partner):

_____

5D - Worker's occupation and main tasks

Occupation: _____

Main tasks: _____

_____

_____

Section 6 - Income support

Please complete section 6 if claiming for loss of wages.

6A - Worker's hours

Is the worker:

☐ permanent or ☐ casual

Normal hours per week? _____ hours

Regular hours each day of the week:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	
☐	☐	☐	☐	☐	☐	☐	OR

☐ tick if not regular hours (e.g. shiftwork)

Is the worker:

☐ full time or ☐ part time

If the worker works part time, what would their hours be

if they worked full time? _____ per week (if known)

6B - Worker's income details

What was the worker's gross weekly wage at

the time of the injury? $ ☐☐☐☐

Does the worker normally work overtime?

☐ Yes ☐ No

If yes, what is the average amount earned per week? $ ☐☐☐☐

What are the average hours of overtime per week? ☐☐

Does the worker receive non-cash benefits? ☐ Yes ☐ No

If 'Yes' what is the benefit? (e.g. car, phone, computer)

_____

(Note: 12 months of wages information may be requested in order to determine Average Weekly Earnings.)

6C - Other employment details

Does the worker have any other current employment?

☐ Yes ☐ No

Section 7 - EFT details

Payments and reimbursements are paid by EFT.

7A - Worker's Electronic Funds Transfer (EFT) details

Bank name: _____

BSB number: ☐☐☐ / ☐☐☐

Account number: _____

Account name: _____

7B - Employer's EFT details

Bank name: _____

BSB number: ☐☐☐ / ☐☐☐

Account number: _____

Account name: _____

Section 8 - Notification of injury

Notification details

When was the employer notified of the injury?

Date: ☐☐ / ☐☐ / ☐☐☐☐

Name of person notified: _____

Position/title of person notified: _____

Person notifying: ☐ Worker ☐ Other, please specify:

_____

Date claim form given to/completed with employer:

☐☐ / ☐☐ / ☐☐☐☐

Section 9 - Other information

Provide any other information relevant to the assessment of the claim:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Important information—read before completing sections 10 and 11

It is intended that the worker and employer complete this form together. If this is the case, the employer should complete section 10 and the worker section 11. If not, only the person (worker or employer) completing the form should sign the relevant section.

Section 10 - Employer declaration

I acknowledge that it is an offence against the *Return to Work Act 2014* to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise ReturnToWorkSA:

- if my circumstances change
- if I become aware of any matter that would make the above information false or misleading
- of any change in the worker's return to work status.

Employer's full name (or authorised person): _____

_____

Employer's signature: _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Section 11 - Medical authority & worker declaration

Only the worker can complete this section.

I give permission for:

- my medical experts to provide ReturntoWorkSA, my employer's claims agent or my self-insured employer with information relating, and/or relevant to my work injury, condition or illness.
- any of my medical experts to receive x-rays, medical records or reports relating to my claim (including copies) for the purpose of writing a report about my injury, condition or illness related issue.
- ReturnToWorkSA or my employer's claims agent, or my self-insured employer to release my personal contact information to an independent medical examiner for the purpose of an appointment reminder.

A photocopy of this medical authority is valid.

I acknowledge that it is an offence against the *Return to Work Act 2014* to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise ReturnToWorkSA if:

- my circumstances change
- I become aware of any matter that would make the above information false or misleading.
- I undertake any employment (paid or unpaid), including self-employment, during my claim.

Worker's full name: _____

_____

Worker's signature: _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Next steps

When the claims agent receives this completed claim form they:

- will contact the worker and employer
- may request additional information such as information to assist in determining the rate of weekly payments
- will assess and determine the claim for income support and/or medical services
- will arrange services to help the worker to recover and return to work. This may include visiting the worker and the employer if the worker is likely to be away from work for more than two weeks.

Workers of self-insured organisations should discuss the next steps with their employer.

Keep a copy of this completed form for your records.

Scan the QR code to visit our website for more information about making a claim and employer and worker rights and responsibilities.

www.rtwsa.com

RTWSA.P.VIC.1444.v4PA.4.12.2015