Workers Compensation Claim Form

Workers Rehabilitation and Compensation Act 1988

This form is required to make a workers compensation claim for your work-related injury. It includes a worker section for you to complete, and a section for your employer to complete.

You and your employer's rights and responsibilities under the *Workers Rehabilitation and Compensation Act 1988* are included at the end of the worker's section and the employer's section.

If you have questions about the claim process, you can talk to your employer, visit www.worksafe.tas.gov.au or contact Worker Assist Tasmania. Worker Assist Tasmania provides free, independent and confidential advice about workers compensation, rehabilitation and return-to-work to all Tasmanian workers. If you need help, call them on (03) 62 167677 or visit their website, www.workerassist.org.au

WORKER SECTION

How to make a claim

- Report the injury to your employer.
- See a doctor and get a Workers Compensation Certificate of Capacity (medical certificate).
- Complete this form and submit it to your employer with the Workers Compensation Certificate of Capacity (medical certificate). **The processing of your claim can start once you submit both this completed claim form and your Workers Compensation Certificate of Capacity (medical certificate) to your employer.**
- Your employer must complete their section of this form and forward it to their insurer* within 5 working days.
- As soon as your employer receives your claim form and Workers Compensation Certificate of Capacity (medical certificate) they must cover your (reasonable and necessary) medical and associated expenses, and if you are not able to work they must start paying your wages (which are called weekly payments). These payments must be made by your employer even if they intend to dispute your claim.
- Your employer or its insurer must notify you of the status of your claim within 28 days, but may take up to 84 days to make its final decision to accept liability or dispute the claim.

* *Unless your employer is a self-insurer or State Government, who manage the claims internally.*

Completing this form

- You may ask someone else to help you fill in this form.
- If completing by hand, please ensure answers are legible and use a dark pen. Use an X when selecting options.
- Complete all questions in the worker section.
- Find out who you need to forward this form to at your employer and how (eg. an email address to send it to, or where to deliver it by hand or post. If in doubt, post it to the employer's business address).
- Forward the completed claim form and your Workers Compensation Certificate of Capacity (medical certificate) to your employer.
- Keep a record of your submitted claim form and all Workers Compensation Certificates of Capacity (medical certificates), plus any other relevant paperwork and correspondence.

1. Your details

Given name(s):

Surname: Date of birth: / /

Contact phone number:

Email:

Residential address:

Suburb: State: Postcode:

Postal address:

◯ Same as above ◯ Different:

Suburb: State: Postcode:

How do you describe your gender? Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

◯ Woman or female ◯ Man or male ◯ Non-binary ◯ Prefer not to answer

◯ I use a different term. Please specify:

Do you consent to receive communication about your claim electronically?
You will need to monitor emails regularly as time limits apply to claiming compensation. Yes ◯ No ◯

Preferred language (if not English): Do you require an interpreter? Yes ◯ No ◯

2. Your injury details

At the time of injury what was your occupation?

At the time of injury did you have any other paid work? Yes ◯ No ◯

Details:

It is important that you clearly describe how your injury occurred and what caused it. Provide as much information as possible and avoid using abbreviations, acronyms and brand names. This will assist with the assessment and management of your claim.

Date of injury or when you became totally or partially incapacitated, that is, unable to do some or all of your job: / /

Time of injury (if applicable): : AM ◯ PM ◯

Date stopped work (if applicable): / /

Time stopped work (if applicable): : AM ◯ PM ◯

Where did the injury occur?
eg. warehouse, mining site, government offices, primary school, farm. If there were multiple sites you can list these. If you are unsure of how to answer, enter your employer's usual business address.

Address where injury occurred:

Suburb: State: Postcode:

When the injury occurred were you:

◯ working at your normal workplace
◯ working at a different workplace
◯ working from home
◯ in a road traffic accident while working (as driver, passenger or pedestrian)
◯ on a break at work
◯ on a break away from work
◯ travelling between home and work
◯ other, give details:

Describe what happened and how the injury occurred in as much detail as possible. Include:

- What happened
- What was involved, including objects, chemicals, people and physical environment

eg. I felt intense pain in my left arm and shoulder while lifting a box of cat food tins, or, I was knocked off ladder by tractor and the tractor ran over legs, or, I was bullied by my supervisor through constant verbal abuse, or, I am feeling overwhelmed because of increasing workload.

If you need more space for your answer, you can type/write on an extra blank page and include it with this form.

What are your injuries?
Include details of all injuries relating to this claim. This might include more than one injury. Be as specific as you can. Include body location for physical injuries. eg. torn ligament in left shoulder, fractured left leg and bruising, anxiety, depression.

What is the most serious injury (if more than one injury)?

Did anybody see the incident/injury? Yes ◯ No ◯
If yes, who?

Name: Position (if known):

Phone number/email (if known):

When did you first report the injury? / /

Who did you first report the injury to?

Name: Position:

Phone no.:

Who is your primary treating medical practitioner?
The person who will be providing ongoing care/treatment for this injury.

What is the name of the medical practice?

Is this injury only related to this occurrence? Yes ◯ No ◯
If no, give details:

Have you had any similar injuries before? Yes ◯ No ◯
If yes, give details:

Have you had treatment for this type of injury before? Yes ◯ No ◯
If yes, give details:

Have you had any similar or related workers compensation claims (at your current or any previous employment)? Yes ◯ No ◯
If yes, give details:

3. Your declaration (required)

I acknowledge that is an offence to make a false and misleading statement in connection with my claim (under section 153 of the *Workers Rehabilitation and Compensation Act 1988).*

Signature:
On completion of this form, print and sign by hand.

When you finish this form, print and sign in this box by hand.

Date: / /

Full name:

4. Your consent and authority to release your medical information (optional)

This section asks for your consent and authority to release your medical information related to this workers compensation claim. Selecting 'yes' below means that medical information about your injury can be shared with your employer and/or their insurer. You don't have to provide this consent and authority but if you do (by selecting 'yes' below) your claim may be assessed more quickly.

If you do provide your consent and authority (by selecting 'yes' and signing below), you can withdraw this consent and authority at any time in writing to your employer and/or their insurer. However, if you withdraw it, your claim may then take longer to be assessed.

Select yes or no and sign in the box below.

◯ Yes - I consent to and authorise any doctor, hospital, health authority, allied health provider or workplace rehabilitation provider who has provided me with a treatment/service in connection with an injury/condition related to this claim to provide my employer and/or my employer's insurer with medical information, including copies of records.

◯ No - I do not consent to or authorise my medical information being released. I understand this may mean my claim takes longer to assess.

Signature:
On completion of this form, print and sign by hand.

When you finish this form, print and sign in this box by hand.

Full name:

Date: / /

Date you gave this completed claim form to your employer: / /

Print form

Worker checklist and additional information

Make sure you:

- ➔ Answer all questions in the worker section.
- ➔ Read and sign your declaration (section 3). This is required for your claim to progress.
- ➔ Read, select 'yes' or 'no', and sign your consent and authority to release your medical information (section 4). You don't have to provide this consent and authority but if you do (by selecting 'yes') your claim may be assessed more quickly.
- ➔ Include your Workers Compensation Certificate of Capacity (medical certificate) with this claim form.
- ➔ Forward this form along with your Workers Compensation Certificate of Capacity (medical certificate) to your employer.
- ➔ Check that your employer has received your claim form and certificate.
- ➔ Keep records of any documents and correspondence including dates.

Next steps: You

- You should send any ongoing workers compensation Certificates of Capacity (medical certificates) or invoices for medical or other treatment to your employer as soon as you receive them.
- You should keep in contact with your employer.
- You should advise your employer and/or their insurer if your circumstances change (such as if you start working for another organisation or you change contact details)

Next steps: Your employer (or insurer acting on their behalf)

- They must start making wage payments covered by your Workers Compensation Certificate of Capacity (medical certificate) either on the next pay day after the claim is lodged, or if that is not possible, no later than 14 days after receiving the claim. If your pay day is more than 14 days after you lodge your claim, they should commence wage payments on that day.
- They must pay any reasonable and necessary expenses incurred by you as a result of the injury such as medical, rehabilitation and travel expenses.
- They will provide you with a copy of the completed claim form.
- They will provide you with information about the responsibilities of other parties involved in the management of your claim and return to work, eg. injury management co-ordinator, workplace rehabilitation provider.
- They will initiate contact between all parties: you, your treating doctor, and their insurer. This is to discuss your injury, treatment and return to work. This should include providing you with suitable alternative duties within restrictions indicated on your Workers Compensation Certificates of Capacity (medical certificates).

Information about your personal and health information

Your employer and/or your employer's insurer need to collect, use and share personal and health information about you to assess, manage, investigate and otherwise deal with this claim, subject to the limitations provided in Section 158 of the *Workers Rehabilitation and Compensation Act 1988*.

- Personal and health information may be **collected** from your current, previous and future employers, medical practitioners, health service providers, other service providers, government agencies, and any other person or organisation authorised by you, or by law.
- Your employer/employer's insurer may **disclose** personal and health information about you to medical practitioners, health service providers, other service providers, legal practitioners, any other party providing services to the insurer or any agent of these, insurance intermediaries, or another insurer in relation to this claim, and any other person, organisation or government agency authorised by you, or by law.
- In addition, your employer or your employer's insurer are required under the *Workers Rehabilitation and Compensation Act 1988* to **provide information** about all workers compensation claims to WorkCover Tasmania. WorkCover Tasmania may **use and disclose** this information in accordance with the *Workers Rehabilitation and Compensation Act 1988* for regulatory monitoring, reporting and research purposes.

All parties who handle your information have obligations to comply with privacy laws that deal with the collection, use, storage and disclosure of personal and health information, and the *Workers Rehabilitation and Compensation Act 1988*.

Your rights and responsibilities

- You have the right to choose your own treating doctor.
- You may have the right to claim lost wages from other jobs if you have another job/s that your injury prevents you from doing.
- You have the responsibility to attend certain medical appointments at the request of your employer/insurer.
- You have the responsibility to give this claim form to the correct person at your employer.
- You have the responsibility to work together with your employer, the insurer, doctor and others involved in developing a return to work plan to coordinate and manage any treatment, rehabilitation or retraining required.
- You have the responsibility to fully participate in your return to work program once developed.
- You have the responsibility to notify the insurer of any change in your circumstances that may impact the accuracy of the claim information.

END OF WORKER SECTION.

Your employer needs to complete the next section.

EMPLOYER SECTION

This section needs to be completed by the injured worker's employer.

Completing this form

- You will need to know the details of your workers compensation insurance company.
- Review the injured worker's section, ensuring they have completed all questions.
- Complete all questions in the employer section.
- If completing by hand, please ensure answers are legible and use a dark pen. Use an X when selecting options.
- Ensure the worker has also provided you with a copy of their Workers Compensation Certificate of Capacity (medical certificate). A valid claim requires a completed claim form and a Workers Compensation Certificate of Capacity (medical certificate).

1. Employer details

Employer's legal name:
eg. registered company name, State Government agency, partnership, sole trader's name.

Employer's trading name or State Government division:

Australian business number (ABN):

Workers compensation insurance policy number (if known):

Employer's business address:

Suburb:

State:

Postcode:

Contact person
This should be someone who is able to discuss and make decisions about the claim.

Name:

Position:

Phone no.:

Email:

2. Claim details

Date you received the completed claim form from the injured worker:	/ /
Date you received the Workers Compensation Certificate of Capacity (medical certificate) from the injured worker:	/ /
Date you notified your insurer of the injury:	/ /
Date you notified your insurer of the claim:	/ /
Date you sent the claim form and Workers Compensation Certificate of Capacity (medical certificate) to your insurer (not applicable to self-insurers or State Service agencies):	/ /
Do you consent to receive communication about the claim electronically? You will need to monitor emails regularly as time limits apply.	Yes ◯ No ◯
Have you considered what suitable alternative duties could be provided within restrictions/modifications indicated on the Workers Compensation Certificate of Capacity (medical certificate)? If applicable, your insurer will contact you to discuss this further.	Yes ◯ No ◯ N/A ◯

3. Worker employment details

Date the worker started working with your organisation: ☐☐ / ☐☐ / ☐☐

At the time of injury what was the worker's position/title?

At the time of injury what was the worker's employment type (select one option from each of the three sections below)?

- ◯ Direct employee
- ◯ Working director
- ◯ Contractor
- ◯ Employee of contractor
- ◯ Sub-contracter
- ◯ Labour hire worker
- ◯ Apprentice/trainee
- ◯ Volunteer
- ◯ Visa worker
- ◯ Other, give details:

- ◯ Permanent
- ◯ Temporary
- ◯ Casual
- ◯ Other, give details:

- ◯ Full-time
- ◯ Part-time

At the time of injury, what was the worker's:

Normal weekly earnings:

Ordinary time rate of pay:

Average hours worked each day:

Average days worked each week:

Guidance on calculating weekly payments is provided at the end of this form.

4. Employer declaration

I acknowledge that is an offence to make a false and misleading statement in connection with my claim (under section 153 of the *Workers Rehabilitation and Compensation Act 1988).*

Signature:

Full name:

Date: ☐☐ / ☐☐ / ☐☐

Employer checklist

Make sure you:

- ➔ Tell your insurer within 3 working days that you have received this claim.
- ➔ Complete all questions in the employer section.
- ➔ Check the worker has completed all questions in the worker section.
- ➔ Forward this form to your workers compensation insurer within 5 working days of receiving it. Make sure you also forward:
  - → the worker's Workers Compensation Certificate of Capacity (medical certificate).
  - → any invoices or receipts for medical or other treatment.
- ➔ Keep records of any documents and correspondence including dates.
- ➔ Provide a copy of the completed form to the injured worker.
- ➔ Contact your insurer if you have any concerns or believe further information is required to assess the claim.
- ➔ Keep in contact with the worker (as appropriate) and provide them with the encouragement and support they need.

Next steps: You as the employer (or insurer acting on your behalf)

- If the worker has been certified by a Workers Compensation Certificate of Capacity (medical certificate), you must start making weekly payments. If the pay day is more than 14 days after the claim was lodged, you should start weekly payments on that day.
- You must pay any reasonable and necessary expenses incurred by the worker as a result of the injury, such as medical, rehabilitation and travel expenses.
- You must provide the injured worker with information about the responsibilities of other parties involved in the management of their claim and return to work eg. injury management co-ordinator, workplace rehabilitation provider.
- You should initiate contact between all parties: worker, insurer and treating doctor. This is to discuss the injury, treatment and return to work. This discussion should include providing the worker with suitable alternative duties within restrictions indicated on the Workers Compensation Certificate of Capacity (medical certificate).
- You must, within 28 days of receiving the completed claim, advise the worker in writing whether a decision has or has not been made to accept their claim. If a decision has not been made you must tell the injured worker the reason why it has not and what steps you are taking to make a decision. At a minimum you must either accept or dispute the claim within 84 days.

Your rights and responsibilities

- If the worker has been certified by a Workers Compensation Certificate of Capacity (medical certificate) that they are incapacitated for work, you must start making weekly payments on the first pay day after the claim was lodged, or if that is not possible, no later than 14 days after the claim was lodged. If the first pay day is more than 14 days after the claim was lodged, you must start making weekly payments on that day.
- You have the right to discuss the worker's injury and return to work with the treating doctor provided they have signed the medical authority in section 4 of this form.
- You have the right to discuss the claim with your insurer.
- You have the responsibility to submit the claim form to the correct insurer and you must submit it within 5 working days of receiving it.
- You have the responsibility to implement a return to work program when a doctor declares the worker fit for work in any capacity, if required.
- You have the responsibility to keep the worker's original position available for 12 months following a claim.

Calculating weekly payments

A worker is entitled to weekly payments. These payments should be based on the normal weekly earnings or the ordinary time rate, **whichever is the greater amount** (see below).

Normal weekly earnings is the worker's earnings averaged over the 12 months of continuous employment prior to the start of the incapacity.

- If the worker has been employed for less than 12 months, then the earnings should be averaged across the period they have been employed.
- If the worker has been employed for less than 14 days, the normal weekly earnings should be calculated as the normal weekly earnings of another worker performing the same role. If there is no other worker, the injured worker's expected salary excluding overtime or allowances.

Normal weekly earnings include any regular allowances, but not travel or accommodation allowances. Overtime is excluded unless it is part of a regular pattern of employment.

Ordinary time rate is the rate of pay for the employment (as set by an Award or other industrial instrument such as a workplace agreement) that the worker was engaged in immediately before the incapacity began.

For more information contact:
WorkSafe Tasmania
Phone: 1300 366 322 (within Tasmania)
(03) 6166 4600 (outside Tasmania)
Email: wstinfo@justice.tas.gov.au

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