Employee Claim Form

This form is to be completed to make a formal claim for workers compensation in accordance with the *Workers Compensation Act 1987* and *Workplace Injury Management and Workers Compensation Act 1998*.

To _____ Employer's name

Whilst in your employ I sustained the injury described below and elect to make a claim for weekly payments or medical, hospital and rehabilitation expenses.

Worker details

Title | Given name(s) | Surname

Date of birth | Gender Male ☐ Female ☐

Street address, include unit/street/property or lot number as applicable | State | Postcode

Postal address, if different from street address | State | Postcode

Mobile number | Daytime contact number

Email address

Do you require an interpreter? Yes ☐ No ☐ | If yes, which language?

Do you have any special communication needs because of a disability? For example, hearing or vision impairment

What happened

How did the injury occur and what were you doing at the time? For example, slipped and fell to the ground while climbing a ladder

Where did the injury occur? For example, works depot | Is this your usual workplace? Yes ☐ No ☐

Street address where injury occurred | State | Postcode

Name and address of any person(s) present, who may have witnessed the injury

Title | Given name(s) | Surname | Position

Address | State | Postcode

Title | Given name(s) | Surname | Position

Address | State | Postcode

Injury details

Date of injury (dd/mm/yyyy)

Time of injury (hh:mm) am/pm

What injury, injuries, condition or disease did you suffer? For example, open wound, broken bone

What part(s) of your body were affected? For example, right upper arm, lower back

When did you first notice or experience symptoms because of the injury? (dd/mm/yyyy)

Did you stop work because of the injury? Yes ☐ No ☐

If yes, date you stopped work

Date you returned to work, if applicable

Name of the person you reported the injury to

Position

Date reported

If you did not report the injury immediately, please explain the reason for the delay

Medical treatment

What treatment(s) did you receive for this injury or condition?

☐ Medical practitioner ☐ Hospital ☐ None

☐ Other ☐ Ambulance ☐ First aid

If other, specify:

Date of first treatment for this injury or condition

Name of doctor and/or hospital, if applicable

Address

State

Postcode

Contact number

Email address

Were you provided with a workers' compensation medical certificate? If yes, submit it with this form Yes ☐ No ☐

Other similar injuries

Have you suffered a similar injury or condition in the past? Yes ☐ No ☐

If yes, date or period of previous injury or condition

Has the injury or condition resolved? Yes ☐ No ☐

Describe the previous injury or condition, and treatment

Was it a personal injury claim? For example, CTP, workers compensation, public liability, etc. Yes ☐ No ☐

Name of employer, if applicable

Name of insurer

Claim number, if known

Employment

Date started at council

Date started in current position

Type of employment

☐ Full time ☐ Part time ☐ Permanent ☐ Casual ☐ Shift
☐ Temporary ☐ Contractor ☐ Volunteer ☐ Seasonal ☐ Other

Usual days and hours of work

Hourly rate $

Position / Usual occupation

Name of supervisor

Contact number

Do you have any other employment? That is, now or at the time of your injury did you have other employment or self-employment?

No ☐ Yes ☐

Other employment ☐ Self-employment ☐

If yes, full name of other employer

Duration of other employment

Address of other employer

State

Postcode

Collection of personal and health information

StateCover collects personal and health information about you from various sources for the purpose of processing, assessing and managing your claim.

It may be collected from your current, previous and future employers, government agencies, credit reporting agencies, health service providers and other persons who can provide information relevant to your claim. Personal health information about you may also be collected by solicitors, private investigators, loss adjusters and other service providers acting on behalf of StateCover.

Personal and health information is collected for the purposes of enabling StateCover to process, assess and manage your claim and to verify any information you may submit in support of your claim. The information may also be used for your rehabilitation, your recovery at work and any legal proceedings arising under the *Workers Compensation Act 1987* or *Workplace Injury Management and Workers Compensation Act 1998*.

For the purposes of processing, assessing and managing your claim and for the purpose of any complaint or enquiry made by you to any authority, StateCover may disclose personal and health information about you to the following organisations, and types of organisations:

- State Insurance Regulatory Authority (SIRA)
- Independent Review Office (IRO)
- your employers
- solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of StateCover in relation to your claim
- the Personal Injury Commission (PIC) and Approved Medical Specialists (AMS)
- a court or tribunal in the course of proceedings under any of the Acts administered by SIRA
- any other person, organisation or government agency authorised by you, or required by law.

You may request access to your personal and health information collected by StateCover, by contacting our office directly and making the request in writing. You may also request the correction of any errors in the personal or health information held by StateCover.

A copy of our Privacy Policy is available on the StateCover website at www.statecover.com.au, in the footer.

Claim number

Date of injury

Employee declaration, authorisation and consent

I,

date of birth

employed by

have read the information in this form. I declare that the information I have supplied in this form, and any attachments to this form, is true and correct to be best of my knowledge. I understand that the making of a false or misleading claim or false or misleading statement in support of the claim is punishable by law and I may be prosecuted.

I understand that if the claim results in my receiving weekly compensation payments, I am required to notify StateCover immediately of any change in my condition or employment that may affect my earnings or claim, and that failure to do so is an offence.

I understand that I am obliged to participate and co-operate in the development and implementation of my Injury Management Plan to assist with my recovery at work, in accordance with medical recommendations. I understand that any failure to do so may affect my entitlement to workers compensation benefits.

Authorisation and consent

I authorise and consent to the collection, disclosure, use and exchange of any personal and health information in connection with my injury/condition to which this claim relates by StateCover, my employer, the State Insurance Regulatory Authority (SIRA) or to any person who provides me with medical, hospital, treatment or rehabilitation services.

I authorise and consent to any person who provides me with medical, hospital, treatment or rehabilitation services in connection with my injury/condition will provide to StateCover, upon their request, any information regarding those services provided to me.

I understand that my authority has effect for the duration of this claim.

A photocopy of this declaration shall be valid as the original.

Signature of worker, or authorised person completing this claim form

Date

Name of authorised person completing this claim form, if applicable

Relationship to worker

Employer declaration

Date claim form received

Cost Centre

Name of council representative

Position

Signature of council representative

Date