# Employee claim form

Complete this form to make a formal claim for workers compensation under the *Workers Compensation Act 1987* and *Workplace Injury Management and Workers Compensation Act 1998*.

To ______________________ Employer's name

I have sustained the below injury while working for you, and I am making a claim for weekly payments and/or medical, hospital and rehabilitation expenses.

## Worker details

Title | Given name(s) | Surname

Date of birth DD/MM/YYYY

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 need an interpreter? Yes ☐ No ☐

If yes, which language?

Do you have any special communication needs because of a disability? E.g. hearing or vision impairment

## What happened

How did the injury occur and what were you doing at the time? E.g. slipped and fell to the ground while climbing a ladder

Where did the injury occur? E.g. 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? E.g. open wound, broken bone

What part(s) of your body were affected? E.g. 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 (specify): ☐ Ambulance ☐ First aid

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 given 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/condition

Has the injury/condition resolved? Yes ☐ No ☐

Describe the previous injury/condition and treatment

Was it a personal injury claim? E.g. CTP, workers compensation, public liability Yes ☐ No ☐

Name of employer, if applicable

Name of insurer

Claim number, if known

## Employment

Date started at current employer ______ 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 or self-employment, now or at the time of injury?

☐ 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.

Should you have any concerns or wish to make a complaint about the handling of your personal information, you may do so by following the process outlined in our Privacy Policy.

A copy of our Privacy Policy is available at **statecover.com.au/privacy**. StateCover may disclose your personal information to recipients who are located overseas. We only disclose your personal information to these organisations when it is necessary for the services they provide StateCover or for us to carry on our business. Where we disclose your personal information to an overseas recipient, we will take reasonable steps to ensure the recipient handles your personal information in accordance with the APPs.

The countries that StateCover may disclose your personal information to in the ordinary course of its business may include US, Hong Kong, New Zealand, Vietnam, Canada, Philippines, India and United Kingdom.

Further information on how StateCover collects, uses and discloses your personal information can be found in our Privacy Policy available at **statecover.com.au/privacy**.

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 information and sensitive information, e.g. health information, in connection with my injury/condition by StateCover, my employer, the State Insurance Regulatory Authority (SIRA) or to any person who provides me with medical, hospital, treatment or rehabilitation services/products.

I authorise and consent to any person who provides me with medical, hospital, treatment or rehabilitation services/products 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 employer representative

Position

Signature of employer representative

Date

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