EMPLOYEE CLAIM FORM

Complete this form to make a workers compensation claim for weekly payments and medical, hospital and rehabilitation expenses.

If you are injured at work, you may be eligible to receive weekly payments and claim the costs of some or all medical treatments and services.

Before completing this form, you should:

- Tell your employer you have been injured at work, and
- Visit your doctor to obtain a certificate of capacity or medical certificate.

This form asks questions about you, your employment, the injury and how it happened to help the insurer assess your claim. This form also asks about your treatment, doctor and your return to work to help the insurer and your employer support your recovery.

How do I complete this form?

Answer the questions on this form as completely as you can. The information you provide on this form may impact your workers compensation claim.

For all claims, you will need to:

- **Complete sections 1, 2, 3, 4, 5, 6, 9 and 10**
- Provide a **certificate of capacity**
- **Sign the declaration** on page 9

If you have had time off work due to the injury you must also complete section 7 and 8, and provide evidence of earnings, such as payslips or bank statements.

Who can I contact for help with this form?

If you need help lodging a claim, you can contact StateCover on 02 8235 2800, or email injurynotification@statecover.net.au.

You can also seek help from SIRA's Workers Compensation Assist on 13 74 72, or your union representative.

Who do I send the completed form to?

Make a copy of this completed form for your records and send the completed form to your employer, and to StateCover at injurynotifications@statecover.net.au.

Provide the following supporting documents with this claim form:

- Signed certificate of capacity from your doctor
- Evidence of earnings, if you have had time off work for the injury, e.g. pay slips or bank statements
- Receipts for any medical treatment or medication that you have paid for
- Supporting documents or statements, if available, e.g. witness statements, reports made to your employer or police reports.

What happens after I submit the form?

StateCover will contact you to discuss any payments you may be entitled to if you need time off work, are working reduced hours and/or need medical treatment.

They will also contact your employer and, if necessary, your nominated treating doctor to determine how best to support your recovery and return to work.

When should I contact the IRO?

The Independent Review Office (IRO) handles complaints about the conduct of insurers that affects a person's rights or entitlements. You may also be eligible to get independent legal assistance from an independent approved lawyer if you have a dispute with your insurer. Lodge a request using the online form at www.iro.nsw.gov.au or contact IRO by phone at 13 94 76.

Information for employers

An employer has a duty to:

- Send this completed form and any attachments to StateCover Mutual within 7 days of receiving it
- Pay the worker their weekly payments if their claim is accepted
- Offer suitable employment to the worker
- Remain in contact with the worker and their treating doctor to create a return to work plan.

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.

Section 1: Worker details

This section asks questions about you, the person who was injured at work.

Title

Given name(s)

Surname

Date of birth (DD/MM/YY)

/ /

Gender

Male Female Non-binary Prefer not to say

Street address

Suburb

State NSW

Postcode

Postal address, if different from street address

Suburb

State NSW

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

Yes No

Section 2: Your job and employer

This section asks questions about your employer, the occupation, role or job that you are employed to do, and your employment status.

Employer name

Date started at current employer

/ /

Date started in current position

/ /

Type of employment (please tick all relevant boxes)

Full time Part time Permanent Casual

Shift Temporary Contractor Volunteer

Seasonal Other

Position/usual occupation

Name of supervisor

Contact number

Do you have any other employment or self-employment, now or at the time of injury? Yes No

Please list details of any other employment, including if you are self-employed, now or at the time of the injury

If yes, full name of other employer

Address of other employer

Duration of other employment

Suburb

State

NSW

Postcode

Section 3: What happened

This section asks about the incident or accident that caused the injury. A work injury may be caused by a single incident (e.g. falling from a ladder) or from repeated incidents over time (e.g. from repeated heavy lifting).

When did the incident occur?

Date (DD/MM/YY)

/ /

Time

: am pm

If more than one incident caused your injury, over what time period did the incidents occur?

What happened and how were you injured?

What task(s) were you doing when you were injured?

Did the incident/s occur at your usual workplace (as identified in Section 2)?

Yes No

If no, what is the street address of where the incident/s occurred?

Suburb

State

NSW

Postcode

Name of employer responsible for this workplace, if known (if different from your employer listed earlier in the form)

How is this location connected to your work? (E.g. a usual place of work, a site you were required to attend for training or other purposes, or a site you were attending for a work-related event.)

Did anyone witness the incident(s) or events that led to your injury?

Yes No

If yes, please provide their names and daytime contact details.

Have you reported the incident that led to your injury to SafeWork NSW, the NSW Police or any other relevant agency?

☐ Yes ☐ No

If yes, please provide the name of the agency and any matter number, event number or completed report (if you have one).

Do any of the of the following circumstances apply? If yes, please select all that apply.

☐ A motor vehicle crash while you were working

☐ While working at your usual workplace

☐ During a meal break or authorised recess at work

☐ While away from work during a recess

☐ While working away from your usual workplace

☐ Travelling to or from work

If your injury was the result of driving or using a motor vehicle or the use of public transport, please provide the following details (if known):

The police station the crash was reported to

Registration number(s) of involved vehicles

Section 4: Your injury

This section asks further questions about your injury. A physical injury is damage (or harm) to the body. A psychological injury is mental harm affecting thoughts, emotions, or behaviour.

Complete 4A if you have a physical injury.
Complete 4B if you have a psychological injury.

You must complete both sections 4A and 4B if you have both a physical and psychological injury arising from the same incident/s.

Is your injury a physical injury or psychological injury?

○ Physical injury: complete section 4A

○ Psychological injury: complete section 4B

○ Both physical and psychological injury: complete both sections 4A and 4B

Section 4A: Physical injury

Complete this section if one of your injuries is a physical injury. If your injury is a psychological injury only, please leave this section blank and instead complete section 4B.

What is your injury, and which parts of your body are affected?

When did the injury occur?

Date (DD/MM/YY) / /

Time : ☐ am ☐ pm

When did you first notice the injury?

/ /

When did you report the injury to your employer?

/ /

What is the name and position of the person you reported the injury to?

If you did not report the injury to your employer, or there was a delay, please explain why.

Have you made a previous claim for another injury that relates to this injury/condition? Please give details, including claim number(s) and insurer details.

Section 4B: Psychological injury

You **must** complete this section if one of your injuries is a psychological injury.

For most workers, psychological injuries are only compensable if they have been caused by a relevant event or series of relevant events. More information about relevant events can be found on page 9.

The information you provide on this form will impact your workers compensation claim.

StateCover encourages you to call for advice on 02 8235 2800 before submitting this form. You can also get help from SIRA's Workers Compensation Assist on 13 74 72 or your union representative.

What is your injury/condition?

Please attach a copy of certificate of capacity which specifies your injury or condition.

When did the injury occur?

Date (DD/MM/YY) Time

/ / : am pm

If your injury or condition developed over time, when did you first notice the injury/condition?

Date (DD/MM/YY)

/ /

Did you report the injury/condition to your employer?

Yes No

If yes, when was this reported to your employer?

Date (DD/MM/YY)

/ /

What is the name and position of the person you reported the injury/condition to?

If you did not report the injury/condition, or there was a delay, please explain why.

Have you made a previous claim for another injury/condition that relates to this injury/condition? Please give details, including claim number(s) and insurer details.

Which relevant event or series of relevant events caused your psychological injury? You may select more than one, if applicable.

More information about each relevant event can be found on **page 8**.

- An act of violence or a threat of violence
- Witnessing a traumatic incident happen
- Death of a person in your care from a traumatic incident
- Bullying*
- Racial harassment*
- Serious criminal conduct
- Witnessing a dead or seriously injured person at the scene of a traumatic incident
- Experiencing vicarious trauma
- Sexual harassment*
- Excessive work demands*

** If your psychological injury was caused by bullying, sexual harassment, racial harassment or excessive work demands, you must complete the following questions.*

In the following questions, the "conduct" means the bullying, sexual harassment, racial harassment or excessive work demands that you were subjected to.

You only need to answer these questions if you are making a claim for a psychological injury caused by bullying, sexual harassment, racial harassment or excessive work demands. You must provide date(s), time(s), location(s), any person(s) involved and how the incident(s) occurred. You may attach supporting statements or documents if available.

Describe the conduct that caused your psychological injury. Please include specific details of the conduct, how many times the conduct occurred and the person or people involved in the conduct.

Please provide examples of specific instances of the conduct, including the date, time and location of the conduct.

Did anyone witness the conduct?

Yes No

If yes, please provide their names and daytime contact details.

Was the conduct reported to your employer?

Yes No

Who was the conduct reported to?

What date/s was it reported? Date (DD/MM/YY)

/ / / /

Please explain the relationship between the conduct and your employment. (E.g. did it occur at your workplace, were the people involved in the conduct other employees or the employer's customers or clients?)

Have you commenced proceedings on this matter in another court or tribunal? For example, in the Industrial Relations Commission or Fair Work Commission.

Yes No

If yes, please provide the proceedings case number, details of your legal representative (if you have one) and details of any orders made by the court or tribunal.

Section 5: Medical treatment

This section asks you to choose a treating doctor and to provide details of other medical providers who have treated your injury. Your nominated treating doctor will work with the insurer, employer, and other treatment providers to manage your injury.

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

Medical practitioner Hospital None

Ambulance First aid Other (specify):

Date of first treatment for this injury or condition Date (DD/MM/YY)

/ /

Name of doctor and/or hospital, if applicable

Address

Suburb

State NSW

Postcode

Contact number

Email address

Were you given a workers compensation certificate of capacity?

Yes No If yes, submit it with this form

Section 6: Other similar injuries or conditions

Have you suffered a similar injury or condition in the past, whether work related or not?

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

Please provide details of medical providers, clinics or hospitals you have attended in relation to the previous condition.

Section 7: Your earnings

If you have had time off from work due to your injury and this has reduced your usual earnings, you may be entitled to weekly payments. To help StateCover calculate weekly payments, this section asks questions about any time off you had, and about your pre-injury earnings.

Did you have to have time off work because of your injury?

☐ Yes ☐ No If no, skip to section 8

If yes, what was the date you last attended work, before taking time off? Date (DD/MM/YY)

/ /

If you have returned to work, what date did you return to work? If you have not returned to work yet, please leave this question blank.

Date (DD/MM/YY)

/ /

Pre-injury earnings

How many hours did you work each week on average before being injured?

What was your hourly rate? (Before tax and deductions)

What were your average earnings per week? (Before tax and deductions}

Please attach copies of any recent payslips with this form (if available).

Have your employment circumstances changed in the past year? E.g. moved from part time to full time, had a pay increase.

☐ Yes ☐ No

If you have/had other employment at the time you were injured, please provide or attach any relevant wage or payment records.

Section 8: Returning to work

If you have returned to work with your employer, what duties are you doing?

○ Full/pre-injury duties ○ Suitable/modified duties

How many hours are you working per week?

Have you returned to work with a new employer?

If you have returned to work with a new employer, please provide the name and contact details of the new employer.

Name

Address

Suburb

State NSW

Postcode

Phone number

Email address

If you have not returned to work, please describe anything that is making it difficult for you to return:

Section 9: 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:

- Employees, contractors and agents of SIRA and insurers
- Your employers
- Other individuals named in the claim form
- Solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of icare or an insurer in relation to the claim
- The Personal Injury Commission and medical assessors
- 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 by law, including the IRO, Industrial Relations Commission, and their employees or agents, to obtain the information.

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.

Section 10: Employee declaration, authorisation and consent

You must sign this declaration before submitting your claim.

Please review and agree to the statements below and sign and date the form.

I,

Date of birth (DD/MM/YY)

/ /

employed by

- Have read the information provided in this form and declare that the information I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge.
- Understand that making a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted.
- Understand that the information I have provided in this form will be used by the insurer to assess liability for the claim I have made, and that this will include sharing the information with my employer and/or other named individuals.
- 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.
- 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.

This form may be signed electronically. A copy, scan, or electronic version of this authority has the same force and effect 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

Addendum

For a primary psychological injury to be compensable, the injury must be caused by one (or more) of the **following relevant events**:

- Being subjected to an **act of violence or the threat of violence**, such as the worker being assaulted or threatened with harm.
- Being subjected to **indictable criminal conduct**, such as robbery or arson.
- **Witnessing a traumatic incident or witnessing a dead or seriously injured person at the scene following a traumatic incident.**

A traumatic incident means any of the following where the incident results in, or is likely to result in, death or serious injury:

- An act of violence,
- Indictable criminal offence, e.g. serious criminal conduct,
- A natural disaster, fire or explosion,
- A motor accident or other accident.

A traumatic incident also includes a suicide or attempted suicide. It also includes where the incident results in the death of a person as a result of an act that is grossly negligent or reckless.

- The **death of a person in the worker's care**, where:
  - The death is the result of a traumatic incident, and
  - There is a real and direct connection between the traumatic incident and the worker's employment, and
  - The person who dies is under the immediate and primary care of the worker, at or near the workplace, at the time of the traumatic incident, and
  - The relationship between the worker and the person who dies is pre-existing, ongoing and close, and
  - The relationship is a requirement of the worker's employment.
- Experiencing **vicarious trauma** where a worker is repeatedly exposed to the traumatic experiences of others as part of their employment.
- Being subjected to **bullying** where an individual or a group of individuals repeatedly behave unreasonably towards the worker or a group of workers of which the worker is a member.
- Being subjected to **sexual harassment** where a person makes an unwelcome sexual advance, or an unwelcome request for sexual favours, to the worker or engages in other unwelcome conduct of a sexual nature towards the worker.
- Being subjected to **racial harassment** where an act is reasonably likely in all the circumstances to offend, insult, humiliate or intimidate the worker, and done because of the race, colour or national or ethnic origin of the worker.
- Being subjected to **excessive work demands** on the worker, which are demands:
  a. Beyond the requirements expected of the worker's role, and
  b. Repeated or persistent, and
  c. Not reasonable in all the circumstances.

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