Workers compensation claim form

WorkCoverSA Better together

Government of South Australia

South Australians with a work-related injury can lodge a claim for workers compensation and may be entitled to income maintenance payments and/or reimbursement of medical expenses paid.

Before making a claim, workers need to:

> notify their employer about the injury

> see a doctor and get a WorkCover Medical Certificate.

How to make a claim for compensation:

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 rehabilitaton and 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 WorkCover Scheme and their worker must ensure this completed and signed form and WorkCover Medical Certificate are sent to the employer's claims agent, either:

Employers Mutual SA
GPO Box 2575, Adelaide SA 5001
newclaims@employersmutualsa.com.au
Fax (08) 8127 1200
www.employersmutual.com.au
Phone (08) 8127 1100 or 1300 365 105

OR

Gallagher Bassett Services Pty Ltd
GPO Box 1772, Adelaide SA 5001
newclaimswcsa@gbtpa.com.au
Fax (08) 8177 8451
www.gallagherbassett.com.au
Phone (08) 8177 8450 or free call 1800 664 079

To find which is the employer's claims agent, use WorkCoverSA's Claims Agent Lookup Service at **www.workcover.com**

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-related injury should speak to their employer about lodging a claim.

Important information for workers

> Report any work-related 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 WorkCover Medical Certificate.

> Be actively involved in your treatment, rehabilitation and return to work, or stay at work plans.

Important information for employers

> This form must be submitted to your claims agent within five business days of you receiving it.

> There are financial incentives for employers who forward the workers compensation claim form together with the WorkCover Medical 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.workcover.com.

> **Immediately 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 and however minor.

Notify SafeWork SA by calling 1800 777 209 or emailing help@safework.sa.gov.au

Copy of the WHS Act available from www.safework.sa.gov.au

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

Need help?

If you have any questions about this form or claiming workers compensation, contact WorkCover Assist on 13 18 55 or visit **www.workcover.com**

Scan with a QR reader to visit our website

Visit www.workcover.com for information on rights and responsibilites for both workers and employers.

To contact WorkCoverSA 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 WorkCoverSA on 13 18 55.

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

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: DD / MM / YYYY

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: DD / MM / YYYY

*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 occured? (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 DD / MM / YYYY Time am/pm

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

If yes, date and time work was stopped:

Date DD / MM / YYYY Time am/pm

Has the worker resumed work? ☐ Yes ☐ No

If yes, date and time worker resumed:

Date DD / MM / YYYY 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 you were or are hospitalised): _____

4B - Medical certificate details

The worker's WorkCover Medical Certificate covers the period

from: DD / MM / YYYY to DD / MM / YYYY

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)

WorkCoverSA employer number: _____

WorkCoverSA location number: _____

Date worker started employment: DD / MM / YYYY

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

_____

Suburb / town: _____ Postcode: _____

5B - Employer contact person for this claim

(e.g. Manager or Rehabilitation and 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 - Compensation payments

Please complete section 6 if claiming for loss of wages.

6A - Worker's hours

Is the worker:

☐ full time or ☐ part time

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)

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)

_____

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: DD / MM / YYYY

Name of person notified: _____

Position/title of person notified: _____

Person notifying: ☐ Worker ☐ Other, please specify:

_____

Date claim form given to/completed with employer:

DD / MM / YYYY

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 *Workers Rehabilitation and Compensation Act 1986* to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise WorkCoverSA:

- 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 DD / MM / YYYY

Section 11 - Medical authority & worker declaration

Only the worker can complete this section.

I give permission for my medical experts to provide WorkCoverSA, my employer's claims agent or my self-insured employer with information relating, and/or relevant, to my work injury, condition or illness.

I also give permission for 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.

I give permission for WorkCoverSA 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 *Workers Rehabilitation and Compensation Act 1986* to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise WorkCoverSA if my circumstances change or if I become aware of any matter that would make the above information false or misleading. I will advise WorkCoverSA if I undertake any employment (paid or unpaid), including self-employment, during my claim.

Worker's full name: _____

_____

Worker's signature: _____

Date DD / MM / YYYY

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 compensation

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

Keep a copy of this completed form for your records.

WorkCover ASSIST

If you have any questions about this form or claiming workers compensation, contact WorkCover Assist on 13 18 55 or visit **www.workcover.com**

Visit www.workcover.com for information on rights and responsibilites for both workers and employers.

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