

IMPORTANT INFORMATION
please read this first

employee's claim for workers compensation

australian capital territory

To (full name of Employer)
I (write full name)
of (write your full postal address)
 Postcode

hereby claim compensation under the Workers Compensation Act 1951 in respect of personal injury sustained by me and arising out of, or in the course of my employment.

1. Please print clearly.
2. Please complete this form as soon as possible after suffering a work related injury. The form should then be given to your employer as soon as possible.
3. Unless otherwise directed, all questions on the form must be answered. Errors or omissions could delay payment of benefits.
4. **A medical certificate from a doctor must accompany a claim for weekly compensation. The certificate required to accompany a claim for weekly compensation must comply with the requirements for medical assessments prescribed under the regulations and include a statement of the doctor's assessment of:**
 - (a) the likelihood of your employment being a substantial contributing factor to the injury; or
 - (b) whether your condition is consistent with your employment being a substantial contributing factor to the injury.
 - (c) The doctor must record the results of the assessment, including the following matters:
 - (i) the aetiology of the worker's injury;
 - (ii) the diagnosis of the injury;
 - (iii) the prognosis for the injury;
 - (iv) the recommended medical treatment for the injury.
 - (d) However, for a later medical assessment of an injured worker, the doctor who does the assessment need record a matter mentioned in (c) only if the doctor considers that there has been a change in the matter.
5. If this form is given to your employer, your employer must forward it to Vero Workers Compensation within 7 days.

Privacy Statement

The Privacy Act 1988(Cth) (as amended) now applies and requires us to inform you that:

Purpose of collection

We collect personal information (this is information or an opinion about an individual whose identity is apparent or can reasonably be ascertained and which relates to a natural living person) from or about you, for the purposes of:

- providing insurance services to you;
- evaluating your application for insurance;
- evaluating any request for amendment to any insurance provided;
- issuing, administering and managing the insurance provided following acceptance of an application; and
- investigating and, if covered, managing claims made in relation to any insurance you have with us or other companies within the Promina Group.

The personal information collected can be used or disclosed by us for a secondary purpose related to those purposes listed above, but only if you would reasonably expect us to use or disclose the information for this secondary purpose.

However for sensitive information, the secondary purpose must be directly related to the purposes listed above.

Disclosure

When necessary and in connection with the purposes listed above, we may disclose your personal information to, and/or receive some personal information from:

- other companies within the Promina Group;
- your insurance intermediary or our agent;
- Government bodies, loss assessors, claims investigators, reinsurers;
- other insurance companies, mailing houses, claims reference providers, legal and other professional advisers;
- other service providers, hospitals, medical and health professionals.

Consequences if information is not provided

If you do not provide us with the information we need we will be unable to consider your application for insurance cover, administer your policy or manage any claim under your policy.

Access

You can request access to the personal information by contacting us at the following address.

Vero Workers Compensation
Level 7, 60 Margaret Street
SYDNEY NSW 2000

In some circumstances we may not agree to allow you access to some or all of the personal information we hold about you such as when it is unlawful to give it to you. In such cases we will give you reasons for our decision.

Collection required by law

Your personal information is, in part, collected in order to comply with Workers' Compensation and Taxation laws.

Section 1 employee's details

First name

Surname

Residential Address

Postcode

Telephone Number

Sex Male Female

Date of Birth / /

Country of Birth

Language Spoken at Home

Interpreter Required No Yes

Marital Status Married/Defacto Not married

Spouse or Defacto Working? No Yes

Occupation

Total dependents including spouse, dependent children (if uncertain please contact Vero Workers Compensation).

Where do you usually work? ACT Elsewhere Combination

Trade Qualification or Skills

Other Qualification or Skills

Employment Details (of the employer for whom you were working when you suffered the injury/disease)

Full Name of Business

Full Name of Employer

Telephone Number

In what capacity were you employed at the time of your injury?

Gross Pay per week \$

Hours Worked per week hours

Do you work overtime in a regular and established pattern?

No Yes Please give details below.

Hours worked overtime per week hours

Overtime rate(s) per hour \$

Are you employed or self-employed in any job other than the one in which you were injured?

No Yes Please give details below

Second current employer

Full Name of Business

Business Address

Postcode

Full Name of Employer

Telephone Number

Position Held by You

Gross Pay per week \$

Hours Worked per week hours

Do you work overtime in a regular and established pattern?

No Yes Please give details below

Hours worked overtime per week hours

Overtime rate(s) per hour \$

If this claim is made more than six months after the occurrence of the accident or incapacity, give reasons for failure to make the claim within that period.

Have you a claim against any person, firm or company for compensation or for any payment in respect of the injury under any law in force in the Territory or any other place?

No Yes Please give details below

Section 2 accident details

Describe in detail what events contributed to your injury/disease. If there was a sequence of events we need to know what started the sequence of events.

How was your injury caused?

What is the address or location where the injury/disease was caused?

Postcode

What is the exact location within the above address where the injury/disease occurred? (e.g. desk, stairs etc)

What were you doing just before the injury occurred?
(e.g. lifting a patient, drilling etc)

How exactly was the injury caused? Give the name of any equipment, product, process or chemical involved (e.g. brakes failed on forklift)

Did anyone witness your injury/disease occurring?

No Yes Please give details below

Name of Witness 1

Address

Postcode

Telephone Number

Name of Witness 2

Address

Postcode

Telephone Number

Do you consider that some person/organisation other than your employer was responsible for or liable to contribute to your injury?

No Yes Please give details below

Section 3 injury details

Date when the injury was caused

Time am/pm

Was the notice of the accident or incapacity served on your employer as soon as possible after being injured?

No Yes On whom?

On what date?

At what time?

 am/pm

If you did not report your injury/disease, please give reason

Have you engaged in any employment since the date of your injury or incapacity?

No Yes Please give full particulars below

State the nature of your injury

What part(s) of your body were affected?

What date did you first have medical treatment for your injury/disease?

What is the name of the doctor, medical practice or hospital that first treated you for your injury/disease?

Did your doctor refer you for any diagnostic tests such as x-rays, pathology, ECG's, evaluation by a psychiatrist or psychologist, or referral to a specialist?

No Yes Please describe the nature of the referral

Name and address of the person you were referred to

First Name

Surname

Address

Postcode

Telephone Number

Was your condition the result of an accident while travelling or while travelling to or from work (commuting)?

No Yes Please ask your employer for a Journey Claim Form to complete

Section 4 disease details

If you are claiming in respect of incapacity arising from an industrial disease, please provide the following details.

What is the nature of the disease?

When was it caused?

When were you first incapacitated by such disease?

What was the nature of your employment and for what period were you engaged thereon?

If you have previously suffered from such disease, state the approximate date on which it first manifested itself

The extent to which it interfered with your employment

Section 5 previous injuries/diseases

Have you previously suffered any related injury/disease before?

No Yes Please give details below

What is the name of the doctor, medical practice or hospital that treated you at that time?

Have you ever claimed for the injury/disease before this claim?

No Yes Please give details below

What was the approximate date(s) of the claim(s) and how long were you off work?

/ /	<input type="text"/>
/ /	<input type="text"/>
/ /	<input type="text"/>
/ /	<input type="text"/>

Name the insurance company the claim was with

Who were you working for at the time?

Section 6 declaration

I (write your full name)

declare that the information given above is true and correct and declare that, to the best of my knowledge and belief, the replies to the questions and requests for information are true and correct in every particular. I understand that while I am in receipt of weekly compensation benefits, I am required to notify Vero Workers Compensation if any of the following occur:

- (1) I commence employment with another employer;
- (2) I commence my own business;
- (3) There is any change in my employment that affects my earnings;

I hereby authorise each medical practitioner, or person in charge of medical facilities, to give Vero Workers Compensation any information held or gathered by the practitioner or person about my medical or factual history, or both, in relation to my injury that happened on

 / /

I agree that Vero Workers Compensation may give a copy of my medical information to any medical specialist, other than my treating doctor, assessing my injury.

I also consent to:

- the use of personal information about me for the purposes shown in the Privacy Statement; and
- the disclosure of personal information about me to, and obtaining personal information from, other parties, including those shown in the Privacy Statement, for any of these purposes.

A photocopy of this authority is as valid as the original.

Declared at on the day of 20 .

Signature of Declarant

Date

 / /

Before me[†]

Date

 / /

Title[‡]

* The claim should be addressed to the person, firm or company in or by which the worker was employed at the time of the accident.

† The person before whom this declaration is made should sign here and add the title by which he or she takes the declaration, such as 'police officer'.

‡ The declaration may be made before any of the following persons:

A postmaster or person in charge of a post office, a magistrate, a justice of the peace, a lawyer, a school head teacher, a police officer, a medical practitioner, a notary public, a commissioner for declarations, a minister of religion, or a member of the Legislative Assembly or the Parliament.

Date Employee's Claim Form received by Employer

 / /

Signature of Employer

Date

 / /