BHP

The Application for Compensation Form – Fatal Injury is an approved form under the

Workers' Compensation and Rehabilitation Act 2003.
The information contained on this page is not part of the approved form.

This 'Important Information' is provided to assist you in completing this form and to give you an understanding of your rights and obligations under the Workers' Compensation and Rehabilitation Act 2003.

References to relevant sections of the *Workers' Compensation and Rehabilitation Act 2003* are included in the following information.

PLEASE READ THIS IMPORTANT INFORMATION

What do you need to do to make a claim?

The entire form must be completed. Please complete all questions as accurately as possible. If a question does not apply to your situation, please write "n/a" or "not applicable" in the relevant area.

If you need assistance in completing the form, please contact the claims management agent, Employers Mutual Limited (EML). The address and contact details for the claims management agent are provided on the last page of the Application for Compensation Form – Fatal Injury.

Space is provided before the end of the form if you have any additional information, diagrams, etc., you would like to include on the form. If there is insufficient space on the form to adequately answer any question, please attach any additional pages of information to the form.

You must attach to the Application for Compensation Form – Fatal Injury a copy of the Death Certificate for the deceased.

What does "posthumous child" refer to?

A "posthumous child" means a child who is born after the death of the worker.

Fraud or false or misleading information

There are severe penalties for fraud, or where there is any attempt to defraud your employer or the claims management agent, or where false or misleading information is provided. Providing false or misleading information in relation to your compensation claim would be an example of this.

Your Privacy

The claims management agent is collecting your personal information in accordance with the *Workers' Compensation and Rehabilitation Act 2003* to assess your entitlement to compensation.

Some of this information may be given to the Office of Industrial Relations – Workers' Compensation Regulator for the purpose of fulfilling their requirements as the regulator, and service providers for the purpose of conducting medical assessments or providing reports or other services to the deceased worker's employer's workers' compensation insurer.

Your information will not be given to any other person unless you have given your consent, or where authorised or required by law.

Right of review of decisions

You have the right to have certain decisions reviewed by the Workers Compensation Regulator.

Act reference: section 540

An example of a decision to which the right of review applies is a decision to reject a compensation application.

Act reference: chapter 13, part 2

Right to appeal review decisions

You have the right to appeal a review decision to the Queensland Industrial Relations Commission and thereafter to appeal the Queensland Industrial Relations Commission's decision to the Industrial Court. You also have the right to appeal a non-reviewable decision to the Industrial Magistrate.

Act reference: sections 549 and 561

An example of a decision to which the right to appeal applies is a review decision about an insurer's decision to reject a compensation application.

Act reference: chapter 13, part 3

How to lodge your Application Form

To lodge your Application for Compensation Form – Fatal Injury, please send the completed form and Death Certificate to the claims management agent, Employers Mutual Limited (EML).

The address and contact details for the claims management agent are provided on the last page of the Application for Compensation Form – Fatal Injury.

Application for Compensation Form – Fatal Injury pursuant to section 132 of the Workers' Compensation and Rehabilitation Act 2003

This Application for Compensation Form is an approved form under the *Workers' Compensation and Rehabilitation Act 2003.*

The entire form must be completed. Please complete all questions as accurately as possible.
If a question does not apply to your situation, please write "not applicable" or "n/a" in the relevant area.

This and the following three pages comprise the approved form.

PLEASE COMPLETE THIS APPLICATION IN BLOCK LETTERS AND TICK BOXES WHERE APPLICABLE

DECEASED'S DETAILS

1. Employee/Payroll Number:
2. Surname or family name:
3. Given or first names:
4. Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
5. Date of birth: / /
6. Gender: ☐ Male ☐ Female ☐ Other
7. Former name: (if applicable)
8. Reason for change?
   (e.g. marriage etc.)
9. Residential address immediately prior to death:

STREET	
SUBURB/TOWN	POSTCODE

EMPLOYER'S DETAILS

10. Full name of employer/site:
11. Business address:

STREET	
SUBURB/TOWN	POSTCODE

12. Which department did the deceased work in?
13. Who was the deceased's supervisor?

EMPLOYMENT DETAILS

14. What was the deceased's job title?
15. Which crew was the deceased in and what roster did the deceased follow?
16. How long was the deceased in their occupation?

YEARS	MONTHS

17. How long was the deceased employed by this employer?

YEARS	MONTHS

APPLICANT'S DETAILS

18. Surname or family name:
19. Given or first names:
20. Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
21. Date of birth: / /
22. Gender: ☐ Male ☐ Female ☐ Other
23. Former name: (if applicable)
24. Do you require an interpreter?
    ☐ Yes *(see below)* ☐ No
    IN WHICH LANGUAGE
25. Present Residential address:

STREET	
SUBURB/TOWN	POSTCODE

26. Do you have a different postal address?
    ☐ Yes *(see below)* ☐ No

STREET	
SUBURB/TOWN	POSTCODE

27. Contact Details:

PHONE
EMAIL

APPLICANT'S DETAILS (continued)

28. Bank details:

NAME OF BANK	
BSB No.	ACCOUNT No.
ACCOUNT NAME	

FATAL INJURY DETAILS

29. Date of death: / /

30. What is the nature of the fatal injury?
(e.g. cut, fracture, clot, heart attack, etc.)

31. Which part of the deceased's body was injured?
(e.g. right leg, head, heart, etc.)

INCIDENT DETAILS

32. Where did the fatal injury occur?
(e.g. Ramp 10, long wall, mine car park)

PLACE	
STREET	
SUBURB/TOWN	POSTCODE

33. Did the fatal injury result from an incident which happened on a specific date?

☐ Yes *(see below)* ☐ No *(go to Q34)*

DAY	DATE	TIME	am/pm

34. If the fatal injury did not result from an incident which happened on a specific date, please indicate:
– the period of time during which your injury happened:

FROM / / TO / /

– when symptoms of the fatal injury were first noticed:

DAY	DATE	TIME	am/pm

– what those symptoms were:

35. When did the fatal injury happen?

☐ Before work ☐ During overtime
☐ After work ☐ During a recess period
☐ Early in shift ☐ Over a period of time
☐ Middle of shift ☐ Unknown
☐ Late in shift

36. Describe what the deceased was doing at the time of the incident, how the incident happened, and how the fatal injury resulted from that incident:

37. Was any object, person or cause involved in the incident?
(e.g. weather conditions, boggy ground, defective equipment)

☐ Yes *(see below)* ☐ No

DETAILS

38. Was the deceased admitted to hospital as an in-patient for this fatal injury?

☐ Yes *(see below)* ☐ No

HOSPITAL NAME			
REASON			
DAY	DATE	TIME	am/pm
PLACE			

39. Please provide the names of all treatment providers who provided treatment or similar assistance prior to death:
(e.g. nurse, physiotherapist, chiropractor, ambulance officer, masseuse, GP or specialist etc.)

40. Did the Queensland Ambulance Service or the Royal Flying Doctor Service attend the deceased?

☐ Yes ☐ No

WITNESS DETAILS

41. Name, address and telephone number of each witness:
(A witness is anyone able to give information about the event - they do not necessarily have to be an eyewitness to the event.)

If there is more information than the space will allow, please provide the details in the space at question 47.

MOTOR VEHICLE DETAILS

42. Details of any motor vehicle/s involved in the incident:
(registration numbers, owners of vehicles and their insurers)

If there is more information than the space will allow, please provide the details in the space at question 47.

DEPENDENCY DETAILS

43.

NAME OF DEPENDENT/S	DATE OF BIRTH	RESIDENTIAL ADDRESS	OCCUPATION	RELATIONSHIP TO DECEASED

44. If applicable, what are the former names of the dependents?

Former name:

When was this former name used?

Reason for change? *(e.g. marriage etc.)*

45. Is there any possibility of a posthumous child?

☐ Yes *(see below)* ☐ No

Expected date of birth:

/ /

46. Details of any other person who may have been dependent on the deceased at the time of death:

47. **ADDITIONAL INFORMATION**

(Space provided for additional information, diagrams, etc.)

PLEASE READ AND COMPLETE THE "APPLICANT'S STATEMENT" ON THE NEXT PAGE

APPLICANT'S STATEMENT

I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information I have provided is true and not misleading.

I agree to advise the claims management agent if my circumstances change or if I become aware of any matter that would make the above information false or misleading.

I authorise any doctor, health authority, allied health provider, rehabilitation provider, or other insurer to disclose to the claims management agent and its agents any information about the deceased worker's medical history relevant to this claim.

I consent to the claims management agent communicating with all parties, including injured workers, employers and medical and allied health providers relevant to this claim.

Signature of Applicant:

Print Name:

Date:

/ /

I declare that the applicant has confirmed to me that they have understood the information about and in this form, and has completed the form to the best of their knowledge.

Signature of Person who Witnessed Applicant's Signature

Print Name:

Date:

/ /

SEND YOUR COMPLETED APPLICATION FORM AND THE DEATH CERTIFICATE TO EML USING THE CONTACT DETAILS LISTED OPPOSITE.

Workers Compensation claims are managed by claims management agent, Employers Mutual Limited (EML) on behalf of BHP Group Limited, the self-insurer.

OFFICE ADDRESS AND ADDRESS FOR SERVICE:

Level 4,
127 Creek Street
Brisbane Queensland 4000

POSTAL ADDRESS

GPO Box 5287
Sydney NSW 2001

TELEPHONE:

1800 469 931

FACSIMILE:

(02) 8002 0560

EMAIL:

bhpselfinsurance@eml.com.au

Who are EML:

Employers Mutual Limited (EML) is a claims management agent and manages all claims on behalf of BHP Group Limited, the self-insurer. EML will confirm your claim number by phone or mail within 28 hours of claim registration. EML then has 20 business days to make a decision on the claim.

If the claim is accepted, it will be managed by an EML Case Manager in conjunction with BHP Group Limited. If the claim is denied, EML will advise you of your rights to review the decision.