INFORMATION FOR WORKERS

This form is to be completed is to be completed if you are an Australian Capital Territory Public Service (ACTPS) employee who wishes to claim workers' compensation under the Safety, Rehabilitation and Compensation Act 1988 (SRC Act'). Parts of this claim form is required to be completed by the worker, and the employer representative. If you need assistance in completing this form, you can contact your employer.

HOW TO MAKE A CLAIM:

- If you have not already told your employer that you have been injured or contracted an illness at work, notify them as soon as possible.
- Either complete this form together with your employer or, once you have answered your questions in the Employee section, then give this form and any attachments to your employer. Your employer will then complete their section and send it to EML.
- If you are no longer employed, you must complete and give the form and attachments to the employer you were working for when you were injured or became ill. If that employer no longer exists or has changed its name, please complete the Employee section of this form and send it to EML.
- If your answers do not fit in the space provided, please attach additional pages with the necessary details.

RESPONSIBILITIES:

Your responsibilities

- Actively engage with your employer and/or your rehabilitation case manager to facilitate your return to work and health.
- Actively participate in your rehabilitation program.
- The '*Managing Injury and Illness in the Workplace*' booklet can be downloaded from ACTPS Employment Portal
- You can also talk to your employer and/or your rehabilitation case manager about your employer's rehabilitation policy and procedures.
- Provide EML with timely, accurate and complete information about your claim. Cooperate and communicate regularly with your employer, rehabilitation case manager and rehabilitation provider about your claim.
- Advise EML as soon as possible about any changes in your circumstances.

Your Employer's responsibilities

- Assist with your rehabilitation and encourage early and safe return to work. Help you find suitable work or a gradual return to work where a return to normal duties is not possible.
- Talk with your treating doctor to understand what jobs/tasks you can safely do at work.
- Assess whether a rehabilitation program is needed, and appoint a rehabilitation provider if required.

EML's responsibilities

- EML has been appointed to manage workers' compensation claims on behalf of the ACT Government from 1 March 2019, for all claims with a date of injury on or after 1 July 1989.
- Work with you, your employer and treating doctors to get you back to health and work. Let you know when your claim has been received and notify you of any decisions and entitlements.
- Deliver appropriate and timely management of your claim, including payment for your treatments and time off work where appropriate.
- Provide rehabilitation and return to work support to both employees and employers.

ATTACHMENTS YOU MUST PROVIDE:

Your claim cannot be assessed unless you attach:

- A Medical certificate for compensation with diagnosis and causation (including what has caused your condition), completed by your doctor or medical specialist, describing your condition and symptoms.
- If you are claiming for a psychological injury you are encouraged to attach a statement outlining the events that contributed to your injury in support of your claim.
- If you are only claiming for medical treatment such as chiropractic, physiotherapy, dentistry or osteopathic treatment and not for time off work, you only need to provide a medical certificate from your treating chiropractor, physiotherapist, dentist or osteopath.

IF YOU NEED MORE INFORMATION:

- Contact your Directorate or Agency who will be assisting you (rehabilitation case manager and/or direct manager).
- Free call EML on 1800 365 227

For information about lodging a claim go to https://www.cmtedd.act.gov.au/employment-framework/wpsafety

For translating or interpreting assistance you can call 13 14 50

PRIVACY STATEMENT

The Australian Capital Territory (represented by the Chief Minister, Treasury and Economic Development Directorate" (hereinafter referred to as CMTEDD) collects, uses and discloses your personal information for the purposes of, or under the Safety, Rehabilitation and Compensation Act 1988 (SRC Act). CMTEDD collects personal information that is reasonably required to manage your compensation claim, any associated rehabilitation or comply with regulatory requirements under the SRC Act and the Work Health and Safety Act 2011 (WHS Act).

If CMTEDD is unable to collect, use and disclose your personal information for the purposes of assessing your claim made under the SRC Act or for related functions, we may not be able to determine or progress your claim. CMTEDD may also need, in accordance with the Information Privacy Act 2014, to collect your personal information from, and disclose your personal information to a number of parties, including the following:

- Employers Mutual Limited (EML) including its contractors, consultants or advisors
- your employer (including any relevant managers) when you were injured
- your current employer and any subsequent employer
- your superannuation fund manager or trustee
- any health professional, hospitals, other health institutions, or service providers related to your claim
- your rehabilitation case manager
- your rehabilitation provider
- vocational and functional assessor
- legal advisors
- law enforcement authorities
- personnel engaged by Comcare to conduct research related activities for the Safety, Rehabilitation and Compensation Commission
- Medicare
- Centrelink
- Inspectors appointed under section 156 of the WHS Act
- any relevant third party for the purposes of assessing, administering, managing, responding or dealing with your compensation claim or any matters connected with your compensation claim.

It is unlikely CMTEDD will provide personal information to anyone in an external territory or outside Australia, unless the information relates to an incident, investigation, injury or illness sustained while overseas, or treatment provided by an overseas practitioner. If disclosure of personal information is made to someone overseas, CMTEDD will follow the Territory Privacy Principles that relate to disclosure to overseas entities.

Accuracy of personal information. CMTEDD wants to ensure personal information is up to date and complete. Our Privacy Policy explains how to access personal information held about you and how to go about making any corrections. A copy of our Privacy Policy can be found on the ACTPS Employment Portal

Complaints. If you think CMTEDD has interfered with or breached your privacy (contrary to the requirements of the Information Privacy Act2014), our Privacy Policy contains information about what you should do and how we will respond. For a copy of our Privacy Policy, to request a change of your personal information or to make a privacy complaint please refer to the ACTPS Employment Portal. You can also contact your Rehabilitation Case Manager, or EML on 1800 365 227, the EML website or email EML at info@eml.com.au

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SECTION 1 - EMPLOYEE TO COMPLETE

YOUR PERSONAL DETAILS

1. Title

2. Given Name(s)

3. Surname

4. Other known or previous names (eg: maiden name)

5. Date of Birth

Day	Month	Year

6. Medicare card number

				-						-		Ref#	

7. Gender

M ☐ F ☐ Other ☐ Prefer not to say ☐

8. Residential / Street Address

Street	
Suburb	
State	Postcode

9. Contact Details

Mobile
Home
Work

10. Manager Details

Name
Email

11. Email address

Email

12. Would you prefer to receive correspondence via;

☐ EMAIL ☐ POST

13. Postal Address *if different from above*

Street	
Suburb	
Street	Postcode

14. If you need an interpreter, what language do you speak?

15. Do you have special communication needs because of a disability? *Eg: hearing or vision impairment*

16. Name of your employer (Directorate or Agency)

17. Do you have any other employment? (self-employment, paid, voluntary, or otherwise)

☐ YES ☐ NO

If YES, please specify

INCIDENT & INJURY DETAILS

18. What is/are the injury(ies) you are claiming for?

19. What part(s) of your body are affected

20. What happened, and how were your injured?

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

22. Was there a witness to the injury, and if so what are their contact details?

☐ YES ☐ NO

If YES

Full Name
Phone Number

23. When did the injury occur?

Date:		Time:	

24. When did you first notice your injury?

25. If you stopped work, what was the date and time?

Date:		Time:	

26. If you resumed work, what was the date and time?

Date:		Time:	

27. When did you report the injury to your employer?

Date:		Time:	

28. Where were you at the time of the injury?

☐ Your usual workplace
☐ On a work break
☐ Working at an alternate location
☐ Working from home
☐ Travelling for work purposes
☐ Engaged in an employer approved activity
☐ Other

Please specify

29. What is the address of where your injury occurred?

30. If your injury was the result of driving, or using a motor vehicle, or the use of public transport, please provide the following details:

a. The Police station it was reported to

b. Registration number(s), and relevant State.

Reg Number	State

SECTION 1 - EMPLOYEE TO COMPLETE

31. Do you believe that your injury was partly or wholly as a result of a third party? *Eg: a manufacturer, or supplier*

32. At the time of the injury, were you taking any prescribed medication or under the influence of alcohol or other drugs?
☐ YES ☐ NO

If YES, please provide details

If you believe that there is further information to assist EML in understanding of your answer to the question above, you can include a signed statement as an attachment with your claim form.

In some circumstances, EML may need to arrange a meeting with an independent investigator to collect a statement and documents from your or others relevant to the injury or your employment.

Do you intend to make a claim, or take any action, against any other third party for this injury (e.g. insurance company, government entity or individual.
☐ YES ☐ NO

If YES, please provide details

You have an alternative to receiving a lump sum payment. This is called a section 45 election. You can find more information at comcare.gov.au under permanent impairment payments.

YOUR MEDICAL TREATMENT

All Medical Certificates for time off work need to be complete by a Legally Qualified Medical Practitioner (LQMP) to be considered valid with your Claim Form.

33. When did you first seek or attend treatment?

34. Name of your Medical Practitioner(s)

35. Specialty of your Medical Practitioner eg: GP, Surgeon, Physio, Chiro etc

36. Location / address of your Medical Practitioner

Practice Name			
Street			
Suburb			
State		Postcode	
P:		F:	

You may be required to attend an Independent Medical Examination throughout your claim. Your EML Case Manager will be able to provide more information regarding this when it happens.

37. Have you ever experienced a similar symptom, injury or illness work-related or otherwise?
☐ YES ☐ NO

38. Have you ever claimed compensation through any insurer, for a similar injury, or condition *eg: claims with the Department of Veterans' Affair, the Dust Diseases Tribunal, or involving a motor vehicle accident, or Workers' Compensation scheme.*
☐ YES ☐ NO

If YES, describe your injury / condition

If YES, what part(s) of your body

If YES, the name of employer that time

If YES, the name of your insurer

If YES, your claim reference number(s)

If YES, the name and details of any health providers

If YES, the name of your Medical Practitioners eg: Doctor

39. Is there any other information that you consider that EML should be made aware of from a Medical Treatment perspective?

YOUR BANKING DETAILS

Any medical expense payments that are due to you will be paid by electronic funds transfer (EFT) into your bank account. Please provide your bank details and sign the authorisation.

1. Payee details

First Name	
Surname	
telephone Number(s)	
Email address	
Street	
Suburb	
State	Postcode

2. Bank account details

Name of Bank	
Account Name	
BSB	
Account Number	

3. . Authority

I authorise payments to be deposited by electronic funds transfer to the bank account nominated in this form.

SECTION 1 - EMPLOYEE TO COMPLETE

I declare that:

- The information I have supplied on this form and any other attachment is true and accurate
- I am aware that I must advise the CMTEDD and EML immediately if I engage in any employment, whether paid or not, or in the running of a business in my own right or as a partner during the period I am absent from work as a result of this injury and/or disease.
- I am aware that I must advise the CMTEDD and EML if my injury or disease improves during any period of incapacity sufficiently to allow me to return to work
- I am aware that the making of a false or misleading claim or false or misleading statement in support of that claim is punishable by law, including under the *Criminal Code* 2002 and, in the event, I may be liable for prosecution
- I am aware that any monies paid by or on behalf of CMTEDD as a result of a false or misleading statement or claim will be recovered

If you refuse or fail, without reasonable excuse, to allow CMTEDD and/or EML and the above parties to use and disclose your personal medical information, CMTEDD and/or EML may be prohibited from dealing with your claim as the information is necessary in order to manage and determine your claim for workers' compensation, to assist with treatment and to perform other functions required by the SRC Act.

Signature: _____ Date: _____

AUTHORITY & CONSENT TO COLLECT, USE AND DISCLOSE INFORMATION (Authority)

I _____ *(Employee's full name)*

Of _____ *(Employee's full private address)*

Date of birth / / Claim number / *(if known)*

Authorise and consent to any doctor, health professional, hospital or other health institution or rehabilitation provider who has examined or treated me for this claimed injury or condition, and any other injury or condition that has developed as a consequence of, or related to my claimed injury or condition, to collect, use, disclose and discuss any reports, clinical notes or other relevant information (my information) relating to this, or other related conditions with the following parties:

- Employers Mutual Limited (EML) including its contractors, consultants or advisors
- your employer (including any relevant managers) when you were injured
- your current employer and any subsequent employer
- your superannuation fund manager or trustee
- any health professional, hospitals, other health institutions, or service providers related to your claim
- your rehabilitation case manager
- your rehabilitation provider
- vocational and functional assessor
- legal advisors
- law enforcement authorities
- personnel engaged by Comcare to conduct research related activities for the Safety, Rehabilitation and Compensation Commission
- Medicare
- Centrelink
- Inspectors appointed under section 156 of the WHS Act
- any relevant third party for the purposes of assessing, administering, managing, responding or dealing with your compensation claim or any matters connected with your compensation claim.

The parties listed above may also collect, use, disclose and discuss my information with each other for the purposes of assessing, administering, managing, responding or dealing with my compensation claim or any other matters connected with my compensation claim.

I understand that collection, use and disclosure of my information as set out above is required for the purposes of determining and managing my compensation claim, and to assist in assessing my treatment needs and capacity for work and/or to assist CMTEDD and EML in any actions authorised under the SRC Act.

I understand that a photocopy or electronic copy of this Authority is a sufficient substitute for the original document.

Signature: _____ Date: _____

SECTION 2- EMPLOYER TO COMPLETE

EMPLOYER DETAILS

1. Employer name (Directorate or Agency)

2. Employer contact detail

Name	
Street	
Suburb	
State	Postcode
Phone	
Email	

3. Rehabilitation Case Manager details

Name	
Street	
Suburb	
State	Postcode
Phone	
Email	

4. Employee AGS or Payroll number

AGS number
Payroll number

5. Your reference number for this claim or employee

6. Liable cost centre name and number

Name
Number

7. Payroll cost centre name and number

Name
Number

8. Do you intend to provide a statement of facts regarding this claim?

☐ YES ☐ NO

If you intend to provide additional information to EML to be considered prior to the determining of this claim, please attach a signed and dated statement within two working days of receiving this claim form from your employee.

9. When were you first notified of the injury

Date:		Time:	

10. When did you receive this claim form?

Date:		Time:	

11. At the time of the injury, was their employment;

☐ Voluntary ☐ Temporary ☐ Permanent

12. Commencement date of employment

Date:		Time:	

13. Before the injury, what were the workers standard weekly working hours

14. How long has the employee been in their current role prior to the injury

15. At the time of the injury, what was the employees job title and main duties

Job title/ Role
Main duties

16. At the time of the injury, was the employee an

☐ Apprentice ☐ Trainee ☐ Neither

17. Has your employee had any time off work as a result of this injury?

☐ YES ☐ NO

18. Has your employee returned to work since the injury?

☐ YES ☐ NO

19. Is the employee still employed with you?

☐ YES ☐ NO

20. Is the employee still employed with the ACT Government? If No, what was the cease date?

☐ YES ☐ NO

Cease date if applicable

If the worker is claiming for time off work, you need to complete a separate *'Claim for time off work'*

21. Employer authorisation

Firstname	
Surname	
Telephone number(s)	
Email address	
Street	
Suburb	
State	Postcode

This form is to be signed by a manager with line management responsibility for the employee at the time they were injured or became ill.

22. Authority

I have read the information I have provided in this form and in any attachments, and declare it is true and correct.
