NSW Workers Compensation Claim Form

COMPLETING THIS FORM

The completion of this form indicates that you wish to claim benefits under the *Safety, Rehabilitation and Compensation Act 1988 (Commonwealth)*, or the *Workers Compensation Act 1987 (NSW)* and/or *Workplace Injury Management and Workers Compensation Act 1998 (NSW)*. Pacific National holds self-insurance licences under both of these Acts. Employees of Pacific National (ACT) are covered by the Commonwealth Act; employees of Pacific National (NSW) are covered by the NSW Act. Employees of Pacific National (NSW) working outside NSW must complete a different claim form, obtainable from the Health Wellbeing & Workers Compensation Group.

- Please print clearly.
- All questions must be completed unless otherwise directed on the form.
- Provide any relevant additional supporting evidence, e.g. witness statements, doctors' reports, etc, and attach them to this claim form at the time of lodgement.
- Keep a photocopy of this claim form and any attachments at the time of lodgement.
- Your injury must be notified through your sites notification procedure.
- This form must be forwarded to the Workers Compensation Group via your supervisor.
- Pacific National needs the information you provide on this form to assist in the determination of your claim and also, to a lesser extent, for occupational health and safety purposes.
- Pacific National may request that you provide further information at a later stage.
- You are entitled to request a copy of any document held by Pacific National that relates to your claim.

YOUR RIGHTS AND RESPONSIBILITIES

- Please ensure you carefully read both this section and each of the questions on the form before signing.
- The information you provide on this form must be true and accurate. Any monies paid by Pacific National as a result of a false or misleading statement or claim will be recovered. Persons who commit or attempt to commit, a fraudulent act against Pacific National may be prosecuted under the *Crimes Act 1914* and/or the *Workers Compensation Act 1987 (NSW).*
- Employees' and claimants' rights are safeguarded by strict privacy controls. These prevent the information contained in this form being used for other than compensation, rehabilitation and occupational health and safety purposes, or other specific circumstances permitted by legislation.
- You may be required to participate in a rehabilitation program. Failure to cooperate with this requirement may result in your workers compensation benefits being suspended or terminated.
- In certain circumstances, information obtained during the course of a compensation claim or rehabilitation program may, according to their specific needs, be given to the following:

  - State Insurance Regulatory Authority (SIRA)
  - Treating and/or other medical practitioners
  - Pacific National's legal representatives
  - Courts, Tribunals and/or other Government Agencies where there is an obligation under law to provide it
  - Pacific National's external providers
  - Your supervisor or manager
  - Law enforcement authorities
  - Superannuation boards
  - Centrelink
  - The NSW Workers Compensation Commission

Employee Details

1. Title
(please tick)

Mr ☐ Mrs ☐ Ms ☐ Other ☐

2. Given Name(s)

3. Family Name

4. Former Family Name (if any)
(if none, leave blank)

5. Sex

Male ☐ Female ☐

6. Date of Birth

/ /

7. Actual Address (residential) **MUST BE COMPLETED**
(please advise **Pacific National** if you change your address)

Postcode:

8. Postal Address
(if same as Actual Address write "as above")

Postcode:

9. Telephone:

Home ( )
Work ( )
Mobile

10. Country of birth:

11. What is the preferred language read or spoken at home? (optional)

12. Do you need an interpreter for an interview?

No ☐ Yes ☐ (if yes, state language preference below)

13. Do you want another person to act on your behalf for this claim?

No ☐ Yes ☐ (if yes, please provide both their name and contact number below)

14. What is your employee number?

Injury/Illness Information

Note: About your Medical Certificate:

- must be an original from a legally qualified medical practitioner (A General Practitioner or Medical Specialist)
- must state a precise diagnosis (certificates containing words such as "medical condition", "back pain", "work related stress" will not be accepted).
- must state the relationship between the injury/illness and your employment.
- must certify any claimed periods of incapacity for work, whether total or partial. (ie. This includes periods where you were capable of performing light duties only)

15. What is the precise diagnosis as stated on your medical certificate?

16. When did your injury happen or when did you notice the illness?

Date / /

Time

Day of the week

17 (a). What date did you first have medical treatment for your injury/illness?

/ /

17 (b). What is the name of the doctor, medical practice or hospital who first treated you for your injury/illness?

18. 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 ☐ Go to 19

Yes ☐ State the nature of referral and give name(s) and address(es) of any specialist consulted or treatment sought. If not enough space, attach another sheet.

Nature of referral

Name and address of doctor

Postcode Tel. No ( )

19 (a). *In your own words,* describe the injury or illness as fully as you can (there is no need to use medical terminology)

19 (b). What part of the body is affected? (eg lower back, left index finger)

19 (c). In your own words describe how this injury now affects you (eg "I am unable to drive a motor vehicle", " I cannot sit for longer than 15 minutes")

20 (a). Have you ever had a similar injury or illness before, work related or otherwise (even if you think it is unrelated to this injury or illness)?

No ☐ Go to 22

Yes ☐ Describe the injury or illness and the parts of the body affected. Give approximate dates.

20 (b). What is the name of the doctor, medical practice of hospital who treated you at that time?

21 (a). Have you ever claimed for the injury(ies) or illness(es) described in questions 18 and 19?

No ☐ Go to 22

Yes ☐ What was the approximate date(s) of the claim(s)?

21 (b). Who was the claim with?

21 (c). Who were you working for at the time?

22. The current injury/illness happened:
(please tick one)

A ☐ While working at your usual workplace

B ☐ Transport accident while working

C ☐ While working elsewhere

D ☐ While having a break

E ☐ While travelling to or from work

F ☐ While attending an approved course of study

G ☐ During an authorised sporting activity

H ☐ Other, provide details below

23. What is the street address or location where the injury/ illness occurred?

Postcode

24. What is the exact location, within the aforementioned address where the injury/illness occurred? (eg my desk, machine shop, fire stairs)

25. Were there any witnesses to your injury/illness?

First Witness

Postcode Tel. No ( )

Second Witness

Postcode Tel. No ( )

26. Describe in detail what events contributed to your injury/illness.

If there was a sequence of events, we need to know:

- what started the sequence of events
- the sequence of events
- the final result

(if not enough space, attach another sheet)

27. Fully describe any equipment or machinery involved in the injury/illness.

Injury on a journey to or from work

28. Was your condition the result of an accident while travelling/commuting?

No ☐ Go to 39

Yes ☐ Go to 29

29. Was the travel or journey during work hours?

No ☐

Yes ☐

30 (a). What were your actual rostered hours of duty on the day of the injury?

From AM PM To AM PM

30 (b). What are your usual hours of duty if different from the above?

From AM PM To AM PM

31. Where were you travelling from?

☐ Workplace

☐ Home

☐ Other, provide details below

32. Where were you travelling to?

☐ Workplace

☐ Home

☐ Other, provide details below

33. What time did you leave?

AM PM

34. What time did you expect to arrive?

AM PM

35. Were there any breaks in your journey prior to your injury?

No ☐

Yes ☐ Please provide details below

36. Did you travel by a direct route?

Yes ☐ Go to 37

No ☐ Please provide details below, including reasons and a map of the route you took

37. Was someone else responsible for your accident?

No ☐ Go to 38

Yes ☐ Please provide full details of the other party including a diagram of what occurred

38. Was the accident reported to the police or anybody else?

No ☐ Go to 39

Yes ☐ Please provide full details including:

- To whom the accident was reported
- Please attach a copy of any report (eg police report, accident report etc)
- Were drugs or alcohol involved in any way?

Incapacity Information

39. Have you returned to work?

No ☐ What date do you expect to return?

/ /

Yes ☐ What date did you return?

/ /

Did you return to:

☐ Your normal working hours

☐ Reduced hours/part time/restricted duties

40. Did you have any other employment (including self employment at the time of injury/illness)?

No ☐ Go to 41

Yes ☐ Name and address of your other employer

How many hours per week do you work for the other employer and what is the gross amount you earned for those hours?

Hours and minutes per week

Gross earnings

41. Dependant details:

Name of Husband/Wife/Defacto

Is he/she working? No ☐ Yes ☐

If yes, what is their average weekly earnings?

Other Dependants:(if not enough space, attach another sheet)

Full Name	Date of Birth	Relationship eg son, parent

42. Have you attached your medical certificate(s)?

No ☐ Remember, Pacific National cannot determine liability on your claim without a medical certificate.

Yes ☐

PLEASE ENSURE THAT YOU READ AND UNDERSTAND ALL OF THE FOLLOWING BEFORE SIGNING THIS FORM.

43. Your authority is required to allow information to be given to Pacific National. Additional medical information will not be requested unless it is necessary to do so. Please complete the following authorisation and declaration.

I,……
authorise the doctors, hospitals, health professionals and rehabilitation providers who have treated me for (insert injury or illness)

…….

to discuss with, or provide to, Pacific National, my Rehabilitation Delegate and/or Rehabilitation Provider, reports or clinical notes relating to this or any similar or related condition.

I authorise the administrator of my superannuation scheme to provide to Pacific National details of medical information obtained in connection with my engagement for employment by Pacific National or its predecessors.

I am willing for a photocopy of this authorisation to be accepted with the same authority as the original. I am willing to allow the distribution of this information to other parties involved in my treatment, rehabilitation or compensation in relation to the injury or illness described above; AND

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 Pacific National 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 injury/illness;

I am aware that I must advise Pacific National if my injury or illness improves during any period of incapacity sufficiently to allow me to return to work, or if I decide to change my treating Doctor;

I am aware that the making of a false or misleading claim or false or misleading statement in support of that claim or to a Medical Practitioner is punishable by law under the *Crimes Act 1914* and/or the *Workers Compensation Act 1987 (NSW)* and that I may be prosecuted;

I am aware that any monies paid by Pacific National as a result of a false or misleading statement or claim will be recovered.

Signature: ☐ **Date:** ☐ / /

You must give or send this form to your Return To Work Co-ordinator (RTWC) or Manager as soon as possible after signing.

This part is to be completed by your Manager

NOTE: This section MUST be completed and the whole form (plus any attachments) are to be forwarded to the Workers Compensation Group within 48 hours of receipt.

1. Name of Employee

Date claim lodged with Pacific National.

/ /

Incident Report No (incident must be reported in the SHED)

(this is a divisional requirement)

2. What was the employee's full cost centre at the date of injury/illness? (eg FCL2151 – Newcastle Train Crew - Coal) **This must be completed.**

3. Has the employee been put on a return to work program?

No ☐ Go to 4

Yes ☐ Please give the starting date of the program and if applicable, the name and address of the Rehabilitation Provider.

Starting date: / /

Name and address of Rehabilitation Provider

4. Who is the RTW Co-ordinator (RTWC)?
(All claims should be reported to the RTWC)

Name

Contact Numbers

Phone: ( )

Mobile:

Facsimile: ( )

5. What was the employee's actual rostered hours on the date of injury/illness?

Start time:

Break: To:

Finish time:

6. Who is the employee's supervisor?

Name

Contact Numbers

Phone: ( )

Mobile:

8. You must not delay in sending this information to the Workers Compensation Group. Failure to lodge claims promptly following receipt from the injured worker may place Pacific National's self-insurance licences at risk.

This form is to be signed by the Site Manager before lodgement.

Note: You should keep a photocopy of all pages submitted for your records.

Signature:

Printed Name:

Telephone

Date: / /

When completed, forward this claim form to:

Workers Compensation Group
Level 16, 15 Blue Street, North Sydney, NSW 2060

Email:
workerscompensation@pacificnational.com.au