Default Insurance Fund

Employee's Workers Compensation Claim Form

Who should complete this form ?

This form should be completed by an ACT worker who has suffered an injury or disease:

- during the course of employment;or
- by any incident arising out of employment; or
- on a journey to or from work;

AND whose employer does not hold an ACT Workers Compensation policy.

How to complete this form

- Please PRINT clearly in black or blue pen only
- Provide as much detail as possible, providing attachments where necessary
- Please ensure that your ACT Workers Compensation Medical Certificate is completed by your treating doctor and attached to the claim.
- Attach all additional supporting evidence you may have to this claim form.
- Keep a photocopy of the completed form and any other supporting documents for your records.
- The completed form should be either
    - Sent to GPO Box 158 Canberra ACT 2601
    - Faxed to (02) 6207 0301 (original copy of form must follow)
    - Delivered to the Canberra Nara Centre, 1 Constitution Ave, Canberra
- A copy of the form is to be forwarded to your employer

Enquiries

If you need assistance in completing this form please contact the Default Insurance Fund on (02) 6207 0723

Please Note

Information collected on this form will be used for the purpose of processing, assessing and managing your claim and to verify evidence you submit in support of your claim.

This information may be given to:

- Medical practitioners and approved rehabilitation providers
- Investigators
- The Default Insurance Fund's legal representatives
- ACT WorkCover and other government agencies

Default Insurance Fund

Employee's Workers Compensation Claim Form

1. Your Details

Given names

Surname

Home address

City/Suburb

State Postcode

Telephone Numbers:

Home: ( )

Work: ( )

Mobile: ( )

Date of birth: / /

☐ Male ☐ Female

Country of birth:

Language at home:

Do you require an interpreter? ☐ Yes ☐ No

2. Marital Status & Dependant Details

Marital Status

Single ☐ Married/De facto ☐ Not Married ☐

Is your spouse/de facto working?

Yes ☐ No ☐

Number of dependants not working:

3. Employment Details

Details of your employment at the time of injury

Occupation/Trade

Type of Employment

Full Time ☐ Permanent: ☐

Part Time ☐ Casual: ☐

Apprentice ☐ Trainee: ☐

Other (provide details:

Date commenced employment: / /

Hours per week: Hourly rate:

4. Employer Details

Employer Company Name (Legal & Trading)

Employer ABN or ACN

Address of employer

City/Suburb

State Postcode

Employer contact(s) (ie. person or people the DI Fund should speak to with regards to your claim)

Telephone Number(s)

( )

( )

( )

5. Other Employment

Prior to injury, did you have any other employment?

☐ Yes ☐ No

Are you currently working with any other employer ?

☐ Yes ☐ No

Details of other employment:

Full time ☐ Part time ☐

Date Commenced: / /

Full Name & Address of **other** employer

City/Suburb

State Postcode

Contact Name:

Telephone: ( )

(If more than one other employer, please attach a separate page)

Have you lost time from work **with this employer** as a result of your injury ? ☐ Yes ☐ No

Date Ceased Work / /

Date Resumed / /

Note: Full details of time lost with all employers are provided in part 7 of this form.

6. Injury Details

Where did the injury occur?

- At work - at normal workplace ☐
- During a break ☐
- Vehicle accident while working ☐
- Travelling to or from work ☐
- Away from work during recess period ☐
- At work - away from normal workplace ☐
- Other ☐

Give details:

The exact location where the injury occurred:

Date and time it happened/you first noticed the injury:

Date _____ Time _____

Date or time you reported it:

Date _____ Time _____

Name of person you reported it to

Position/role of person you reported it to

Telephone number(s)

( )

( )

Type of injury and part of body affected

How did the injury occur ?

7.Time Lost and Pre-Injury Earnings

Have you had time off work as a result of the injury?

No ☐ Yes ☐

Date Ceased Work / /

Date Resumed / /

If you have not resumed work:

Current capacity **(must** be supported by medical certificate):

- Fully fit for work ☐
- Totally unfit for work: ☐
- Partially fit (restricted hours) ☐
- Partially fit (restricted duties) ☐
- Other ☐

Details:

Expected return to work date: / /

If you have not returned to work, and do not expect to return to work, please provide details:

Average Pre-Incapacity Weekly Earnings:

ie. your average gross weekly earnings for the 12 months prior to your injury. The figure is inclusive of any regular overtime, but exclusive of superannuation. Also includes any time lost with other employers as a result of this injury.

Note: Proof of pre-injury earnings must be provided with this form.

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8. Medical Treatment Details

Date first sought medical treatment

Please list all practitioners and hospitals that have treated you in relation to this injury:

Name	Specialty

Briefly outline details of current treatment:

9.Details of Compensation Claimed

Briefly outline details of compensation payments you are or may be seeking.

Incapacity Payments (ie time lost from work)

Treatment Expenses

Permanent Impairment (for permanent injuries)

Other

10. Witnesses

Details of any witness(es) to your injury

1 Name of witness

Address

Postcode

Telephone

( )

Role

2 Name of witness

Address

Postcode

Telephone

( )

Role

If more than two witnesses, please attach a separate page

11. Other related injuries and claims

Have you previously suffered any similar or related injuries? Yes ☐ No ☐

Have you previously made a claim for workers compensation ? Yes ☐ No ☐

Please provide details

Date of injury:	
Nature of Injury:	
Claim lodged ?	Yes No
Employer:	
Insurer:	

Date of injury:	
Nature of Injury:	
Claim lodged ?	Yes No
Employer:	
Insurer:	

If more than one previous injury or claim, please attach a list on a separate page.

12. Journey

Complete this section only if the injury occurred away from your employer's premises OR while you were on a journey to or from work OR a motor vehicle was otherwise involved.

Please detail the journey type *eg. to or from work, during recess period etc*

Were you the:

Driver ☐ Pedestrian ☐

Passenger ☐ Other

What time did you leave and expect to arrive?

Leave Arrive

If deviated from normal journey or if there was an interruption to the journey, explain

Was the injury sustained outside the boundary of the land on which your workplace/home is situated?

Yes ☐ No ☐

If a motor vehicle accident, has a Compulsory Third Party claim been made?

Yes ☐ No ☐

Was the accident reported to the police?

No ☐

Yes ☐ If yes, give details:

Name of police officer and station reported to

Please provide details of all vehicles involved:

Vehicle 1

Driver Name:
Driver Address:
Vehicle Make/Model:
Registration Number:

Vehicle 2

Driver Name:
Driver Address:
Vehicle Make/Model:
Registration Number:

Note: If more than two vehicles were involved, please attach separate list.

Diagram of the accident

Is there anything other information you can provide that may assist us in assessing your claim ?

9. Employee Declaration

I, _____

declare the above statements and particulars are true and correct and that should I receive weekly payments of compensation, I am obliged to notify the insurer immediately if I commence employment with some other person, commence my own business or incur any change in my employment that effects my earnings or earning capacity. I am aware that it is an offence to do so.

I hereby authorise any medical practitioner, rehabilitation provider or other authority to provide the DI Fund with any and all information regarding my medical and or factual history.

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

Have you attached your medical certificate?

Yes ☐

No ☐

Signature

Date

/ /

Note: Please view the Default Insurance Fund Privacy Charter which can be found at: www.treasury.act.gov.au/actia/difund