Default Insurance Fund

Employer's Workers Compensation Claim Form

Who should use this form ?

This form should be completed by an employer who does not hold a compulsory ACT Workers Compensation policy, and who is the employer of an ACT worker who has suffered an injury:

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

How to complete this form

- Please PRINT clearly in black or blue pen only
- Provide as much detail as possible, providing attachments where necessary
- 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

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 the claim and to verify evidence submitted in support of the 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

Employer's Workers Compensation Claim Form

1. Employer Details

Legal Name

Trading Name

ABN or ACN

Name of contact

Position/Role

Location Address

City/Suburb

State | Postcode

Postal address (*if different from location address*)

City/Suburb

State | Postcode

Contact Numbers

Office ( )

Mobile: ( )

Fax ( )

Business activity or profession

Name and location where worker is employed

City/Suburb

State | Postcode

2. Workers Particulars

Given names

Surname

Gender

Male ☐ Female ☐

Date of birth

/ /

Residential address

City/Suburb

State | Postcode

Contact Numbers

Home ( )

Work ( )

Mobile ( )

3. Employment Information

Worker's Occupation

Main tasks performed by worker

Date employed

/ /

If not an employee, explain relationship *(eg. Subcontracter)*

Type of Employment

Full Time ☐ Permanent: ☐

Part Time ☐ Casual: ☐

Apprentice ☐ Trainee: ☐

Other (provide details:

Average Pre-Incapacity Weekly Earnings:

ie. the worker's average gross weekly earnings for the 12 months prior to the injury. The figure is inclusive of any regular overtime, but exclusive of superannuation.

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Standard hours worked per week

Overtime hours worked per week

Number of days worked per week

4. Injury Details

Where did the injury occur?

At work ☐ During a break ☐

Vehicle accident while working ☐

Travelling to place of employment ☐

Travelling from place of employment ☐

Away from work during recess period ☐

Date of injury / /

Time of injury

Date you were notified / /

Time you were notified :

To whom was the accident reported?

Role of person to whom accident was reported:

Address and place where the injury occurred

City/Suburb

State Postcode

Nature of injury *(eg. fracture, strain, laceration)*

Part of body affected:

Describe how the injury occurred:

5. Time lost from work

Did the worker cease work ? No ☐ Yes ☐

Date: / / Time: :

Has the worker resumed work? No ☐ Yes ☐

Date: / / Time: :

Exact time lost:

Days

Hours

Shifts

6. Witnesses

Details of any witness(es) to the 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

7. Rehabilitation and Return to Work

Has a Rehabilitation Program been established to assist the injured worker in returning to work ?

Yes ☐ No ☐

Please provide details:

If the worker is still off work, and not expected to return to work in your employment, or at all, please provide details:

Please note that the DI Fund must appoint a rehabilitation provider in accordance with legislation, if this has not already been attended to.

8. Claims Management

Have you commenced payments of weekly compensation in this matter ? No ☐ Yes ☐

Please provide details, or reasons why not:

Please provide details of any other payments made in this matter (ie. medical, rehabilitation)

If you have any further information that may assist us in assessing the claim, please provide details.
If insufficient space, please attach a separate page

Details of previous injuries or claims if known

9. Employer's Declaration

I, (print name and position)

declare that the details above are true and correct in every particular.

Signature

Date / /

Privacy of personal information

The Default Insurance Fund (DI Fund) is committed to handling personal information in accordance with the Privacy Act.

Collection, security, accessibility and disclosure of personal information

We need to collect, use and disclose information in order for the DI Fund to assess your employee's claim. The Workers Compensation legislation authorises us to collect this information. You can choose not to provide us with the information requested, but this may affect our ability to assess the claim.

The DI Fund will secure all personal information collected, and provide access to this information, in accordance with the Privacy Act.

By providing the personal information to the DI Fund you acknowledge and consent that:
1. Where you provide personal information to us about another person, you are authorised to provide that information to us, and you will inform that person who we are, how we use and disclose their information, and how they can gain access to that information (unless doing so would pose a serious threat to the life or health of any individual).

2. We can collect and use the personal information for the following purposes: to investigate, assess and pay the current claim against you.

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