

# Claim form

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## What is this form?

This form can be used to notify a workplace injury or seek compensation payments if you have been injured at work with an employer registered in South Australia. Alternatively, this information can be provided by telephone (followed by this form) to Employers Mutual, WorkCoverSA or the self-insured employer (see information to the right).

Receiving this information will enable a request for compensation to be considered and will provide sufficient information for the case manager to assist in the return to work process.

If there is insufficient space provided for any of the questions, please attach additional information. A copy of this form should be kept for your records.

## Who can fill out this form?

- An injured worker
- An employer\*
- A representative, such as a treating doctor, first aid officer or a worker's relative or friend or union representative\*\*

**It is important to ensure that the employer (if you are not the employer) has also been provided with these details if you are notifying WorkCover or Employers Mutual directly (unless the worker is not in employment at the time of injury).**

\* An employer may complete this form to notify of an injury or begin the claim process, however they must also complete an *Employer Report Form*.

\*\* Only with the expressed consent of the worker.

## Compensation payments

If a claim cannot be determined within seven days and the mandatory information has been provided and shaded on this form and it is received by WorkCoverSA, Employers Mutual or the self-insured employer, then provisional payments will commence (in most cases).

A claim for medical and other expenses may also be paid on a provisional basis, if a claim cannot be determined within seven days.

A *WorkCover Medical Certificate* from the doctor must also be provided.

The employer and injured worker will receive a letter within seven days advising whether compensation payments will commence and what to do if they don't agree with the decision.

The information in this form can be provided to:

### Employers Mutual

By phone: 1300 365 105

By fax: (08) 8127 1200\*

By post: GPO Box 2575, Adelaide SA 5001

Online at: [www.employersmutual.com.au](http://www.employersmutual.com.au)

OR

### WorkCoverSA

By phone: 13 18 55 (Service Centre)

By fax: (08) 8233 2466\*

By post: GPO Box 2668, Adelaide SA 5001

OR

### Self-insured employer

To the self-insured employer.

*\*forms can be torn at perforation for faxing.*

If you need help filling in this form or have any questions, speak to:

- A supervisor
- The employer's return to work coordinator
- A union representative
- A occupational health and safety officer/representative
- Employers Mutual on 1300 365 105
- WorkCoverSA on 13 18 55.

If you are unable to fill in the form because it is in English, staff from the WorkCover Service Centre will arrange interpreting services. This interpreting service is available at no cost to you.

**Please tick the relevant box**

- I want to give notice of an injury only (no request for weekly payments or medical and other expenses at this time)<sup>1</sup>
- I want to give notice of an injury and claim weekly payments and/or medical expenses<sup>2</sup>

NB: If this claim cannot be determined within seven (7) calendar days, the payment of provisional weekly payments will (in most cases) commence.

## Worker's details

**Worker's family name**

**Other names**

Title Mr  Mrs  Ms  Miss

Does the worker wish to identify as: Aboriginal   
Torres Strait Islander

Gender Male  Female

Date of birth  /  /

Former name/s (if any)

Country of birth

Residential address  
  
 Postcode

Postal address (if the same as residential write 'as above')  
  
 Postcode

Telephone number  
Daytime:   
Mobile:

Email address

Does the worker need an interpreter? Yes  No   
Language spoken or read

Dialect

Has the worker ever had a past workers compensation claim?  
Yes  No

## Employer's details

**Employer's name**

**Employer's address**

  
 Postcode

Employer's registration number, if known

Location number, if known

Contact name (if employer has more than 30 employees, this will usually be the rehabilitation and return to work coordinator)

Telephone

Facsimile

Email

Was there any time lost due to injury/disease? Yes  No

Current gross weekly wage \$   
(inc overtime, shift allowance etc)  
(if time off work)

Hours per week

**Occupation and main tasks**

  

Full time  Part time  Permanent  Casual   
Apprentice  Trainee  State/Federal Award

## Employer notification

Date employer notified of injury\*  /  /

Person notified: Mr  Mrs  Ms  Miss

Family name

Given name

\* The date when the employer received the minimum information (in the shaded boxes) on this form.

## Injury details

Description of injury (injury/disease suffered)

  

How the injury occurred? (what led to the injury occurring)

(Refer overleaf for examples of how to answer this question)

  
  

Part of the body affected (eg, left upper arm, internal organs, etc)

  

Treating doctor's name and/or surgery name

  

Or, if the worker is hospitalised, name of hospital

Doctor/hospital address (include phone number if known)

  
  

Most recent WorkCover Medical Certificate from

 /  /  to  /  / 

Incapacity totally unfit for work  partially unfit to work

When did the injury/disease occur?

- while working at usual workplace  
 traffic accident while working  
 while having a break  
 while travelling to or from work  
 while attending an approved course of study  
 while working elsewhere

other (please specify)

When did the injury happen or when was the injury/disease first noticed?

 /  / 

Time of injury

 am/pm

If the worker stopped work due to injury/disease, what date did they stop work?

 /  / 

## Other current employment

Does the worker have any other current employment?

Yes  No

## Medical authority

If you (the notifier) are not the injured worker, please do not complete this section.

Signing this authority may help the request for compensation to be processed more quickly.

I give permission for my medical experts to provide WorkCoverSA, its claims agent Employers Mutual or my self-insured employer with information relating to my injury or condition. I also give permission for any medical experts to receive x-rays, medical records or reports relating to my claim (including copies) for the purpose of writing a report about my injury or condition. A photocopy of this medical authority is as valid as the original.

Signature of the worker

Date

 /  / 

## Electronic Funds Transfer (EFT) details

Please provide the worker's bank details to have any workers compensation payments deposited directly into their bank account.

Bank BSB number  -

Bank name

Branch address

Account number

Account name

Note: a remittance advice of any payment/s processed via EFT will be sent to the worker via post. Please advise the claims agent (within five days) if any of the bank account details provided are changed.

## Notifier's details

Notifier's name

I am: The worker  The employer  Other

If other, please specify:

  

Address

  

Telephone number

## Rights and responsibilities

### Worker's responsibilities

- To notify their employer as soon as possible if they have been injured in the course of their employment. This may be made to a person in the workplace such as the rehabilitation and return to work coordinator, the health and safety representative or the immediate manager/supervisor. A copy of this form can be used for this purpose.
- To give to their employer any paid accounts for reimbursement or invoices for expenses incurred.
- To provide the self-insured employer or WorkCoverSA with up-to-date *WorkCover Medical Certificates* if requested to do so.
- To be actively involved in their treatment and rehabilitation and comply with the requirements of a rehabilitation and return to work or rehabilitation program.
- To undertake suitable employment that a doctor says they are fit to perform.  
(Note: It is an offence to provide false or misleading information about a claim).

### Worker's rights

- To be paid weekly payments, if incapacitated for work, once a claim form has been received or if a claim cannot be determined within seven days to receive provisional weekly payments, unless a reasonable excuse is applied or no income loss occurs.
- To have reasonable medical and other expenses paid within a reasonable time eg, travel.
- To have a current copy of, and be meaningfully involved in all decisions regarding their approved rehabilitation program/plan.
- To raise with the person managing their claim any dissatisfaction with their allocated rehabilitation provider.
- To have a treating doctor/specialist of their choice and obtain a second opinion from a specialist.
- To be provided with copies of all medical reports concerning their claim within seven (7) business days of Employers Mutual or the self-insured employer receiving them.
- To have a representative or support person present at any meeting or hearing about their claim (eg, family member, union, employee advocate, solicitor).
- To have any personal information kept confidential.
- To have an interpreter at meetings and appointments if required.

### Employer's responsibilities

- To pay the first two weeks of income maintenance unless the employer is a self-insured employer or has previously made weekly payments of at least two weeks during this calendar year to this worker.
- To report to Employers Mutual within five (5) business days of receipt of an injury notification. Failure to notify Employers Mutual of a disability within five (5) business days may incur penalties of \$1000 and imposition of supplementary levies.
- To forward to Employers Mutual any *WorkCover Medical Certificates* and associated paid accounts for reimbursement or invoices for expenses incurred that are received from the worker.
- To complete an *Employer Report Form* and submit it to the claims agent.
- To forward an injured worker's wage information required by the claims agent upon request.
- To provide suitable employment to an injured worker and cooperate with the requirements of rehabilitation programs and rehabilitation and return to work plans.

### Important reminder for employers

If the worker's injury is an **'immediately notifiable work-related injury'** the employer must, if they have not already done so, notify their local regional office of SafeWork SA by telephone 1800 777 209 or fax, pursuant to Reg 6.6.2(1) of the Occupational Health, Safety and Welfare Regulations, 1995. These are work-related injuries that:

- cause death
- show acute symptoms associated with exposure to a substance at work
- require treatment as an inpatient in a hospital immediately after the injury (disregarding any time taken for emergency treatment or transporting the person to hospital).

SafeWork SA can also be contacted by email at [help@safework.sa.gov.au](mailto:help@safework.sa.gov.au).

## How the injury occurred (What led to the injury occurring)? example

Walked outside to front end loader	➔ Slipped over in a puddle of water on driveway	➔ Hitting my head on front end loader
Machining wood on bandsaw	➔ Band saw caught in knot in wood throwing wood out	➔ Wood flying up and hitting head
Using angle grinder	➔ Cast iron chip flew from angle grinder	➔ Foreign body entering unprotected eye
Repeatedly lifting cartons of wine	➔ Lifting heavy cartons	➔ Heavy cartons of wine put strain on back

## Further explanation on the completion of this form

<sup>1</sup>To give **notice of injury only** under section 51 of the *Workers Rehabilitation and Compensation Act 1986* (the Act) means that you wish to give written notice that an injury has occurred, but do not request any compensation payments at this time. If, at a later date, you wish to claim compensation (weekly payments and/or other expenses) you will need to lodge a claim for compensation.

<sup>2</sup>To give **notice of an injury and claim weekly payments and/or medical expenses** means that you seek weekly payments of compensation which, if there is any delay in determining the claim, may be paid initially to you on a provisional basis under Part 4, Division 7A of the Act. Provisional weekly payments will start within seven (7) calendar days (in most cases) but will be limited to 13 weeks of weekly payments. The claim for medical and other expenses is a claim for payment of expenses resulting from your injury and may also be paid to you on a provisional basis under section 32A but will be limited to \$5000. Claims for payments exceeding these limits will only be paid if your claim for compensation under section 52 of the Act is accepted.