

Claim form

Workers' Compensation and Rehabilitation Act 2003



quick info

Workers need to:

- notify employers about injuries
- see a doctor and get a *Workers' Compensation Medical Certificate*.

Claims should be lodged with us as soon as possible. We will assess your claim according to workers' compensation legislation and advise you of the outcome.

lodge a claim

-  **Online** at www.workcoverqld.com.au
-  **By phone** on 1300 362 128
-  **Through a doctor**
-  **By fax** on 1300 651 387
-  **By post** to GPO Box 2459, Brisbane Qld 4001

Before you complete this form, please tell us if you are:

- an injured worker
- an employer
- an injured worker and employer completing the form together

Worker's details

1 Surname or family name

2 Given names Title

3 Previous name/s (if applicable)

4 Date of birth / /

5 Gender male female

6 Current residential address

Number/street	
<input type="text"/>	
Suburb/town	Postcode
<input type="text"/>	<input type="text"/>

7 Postal address

If this is the same as the residential address please write 'as above'

Number/street	
<input type="text"/>	
Suburb/town	Postcode
<input type="text"/>	<input type="text"/>

8 Contact details

Home telephone
Work telephone
Mobile telephone
Email

9 What is the claim for:

- time off work (other than the day of injury)
You will need to complete a *Tax File Number Declaration*
- medical expenses

10 Worker's bank details

We make claim and medical reimbursement payments by electronic funds transfer

Bank name	
BSB number	Account number
<input type="text"/>	<input type="text"/>
Account name	

Employment details

11 Employer's full company name and business address

Name	
Employer or RRTWC contact	
Number/street	
Suburb/town	Postcode
Telephone	Fax
Email	
WorkCover policy number or ABN	
WorkCover Industry Classification (only if >1)	

12 Worker's occupation

13 Was the worker any of the following at the time of the injury?

- a community service worker
- a director of a corporation
- a jockey
- a member of a partnership
- a student
- a trustee
- a contractor
- self-employed
- a worker for another employer
- a volunteer

Injury details

14 When did the injury happen?

Date / / Time : am pm

15 What is the nature of the injury and what part of the body is injured?
e.g. cut right index finger, fractured leg, lower back strain

16 How did the injury happen? e.g. lifting steel rods from the floor to a bench

17 Where did the injury happen? e.g. workshop floor, 6 Smith St, Smithtown

Place	
Number/street	
Suburb/town	Postcode

18 Did the injury happen

- working at the normal workplace
- in a road traffic accident while working
- at work on a break
- on a journey to or from work
- away from work during a recess period
- working away from the normal workplace

19 When was the employer advised about the injury

Date / /

Who was the injury reported to?

20 Employers only: can you confirm that the event occurred at work (or on the worker's way to work) and that the worker suffered a work related injury as a result of that event?

- yes
- no, provide relevant information to help us determine the claim

21 Has a medical certificate been attached to this form?

- yes, go to question 22
 no, fill in the details below

Date the doctor signed or issued the medical certificate?

Date / /

Diagnosis
Doctor's name
Practice/hospital name

Date first seen by doctor Date / /

Workers' capacity for work

fit to return to normal duties from Date / /

fit for suitable duties (restricted hours) from
 Date / / to / /

Restrictions

not able to work at all from

Date / / to / /

Treatment

- no further treatment required
 will require treatment from

Date / / to / /

Treatment required

Wages information

22 Worker's wages/salary

How many hours per week
Gross weekly rate of salary/wages (under award) \$
Gross normal weekly earnings \$

The normal weekly earnings calculator is available on the Employers home page of our web site at <http://www.workcoverqld.com.au>.

23 Worker's hours of work each day of the week

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

24 Has the employer excess been paid to the worker?

- no
 yes, gross amount paid is \$

25 Has the employer continued to pay the worker's salary or wages during the period of incapacity (in addition to the excess)?

- no
 yes, provide employer's bank details for payments to be reimbursed by EFT

Bank name	
BSB number <input type="text"/> - <input type="text"/>	Account number <input type="text"/>
Account name	

26 If the employer is not entitled to claim back all the GST, what percentage can be claimed?

%

27 Reference code or payroll number for the worker

Important information—read before signing this form

This section needs agreement by the person completing the form. If the worker and employer are completing the form together, please complete both sections.

Privacy notice

WorkCover is collecting your personal information in accordance with the *Workers' Compensation and Rehabilitation Act 2003* in order to assess your entitlement to compensation. Some of this information may be given to Q-COMP for the purpose of fulfilling their requirements as the authority and service providers for the purpose of conducting medical assessments or providing reports or other services to WorkCover.

Your information will not be given to any other person unless you have given your consent, or we are authorised or required by law. For more information on privacy, visit our website at www.workcoverqld.com.au or call us on 1300 362 128.

Worker's statement

I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information I have provided is true and not misleading.

I agree to advise WorkCover Queensland if my circumstances change or if I become aware of any matter that would make the above information false or misleading. I will advise WorkCover Queensland if I undertake any employment (paid or unpaid), including self-employment during my claim.

I authorise any doctor, health authority, allied health provider, rehabilitation provider, or other insurer to disclose to WorkCover Queensland and its agents any information about my medical history relevant to this claim.

I have read and understand the privacy notice.

Signature

Date / /

Employer's statement

I have read the information provided with this form. I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information that I have provided is true and not misleading.

I have read and understand the privacy notice.

Signature

what is next?

We will SMS the injured worker their claim number when we receive the claim (if a mobile number is provided).

After you lodge your claim, we have 20 business days to make a decision on it, but we decide most claims within five days.

If your claim is accepted, it may be case managed by one of our customer service centres to assist with return to work.

If you have any questions about your claim or workers' compensation in Queensland, call us on 1300 362 128 or visit our web site at www.workcoverqld.com.au.