WorkCover QUEENSLAND

Claim form

Workers' Compensation and Rehabilitation Act 2003

Before making a claim, workers need to:

- notify employers about injuries
- see a doctor and get a workers' compensation medical certificate.

Make a claim as soon as possible. We will then decide the claim based on workers' compensation legislation and advise you of the outcome.

Make a claim

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

Section A: Tell us who you are

☐ an injured worker
☐ an employer
☐ an injured worker and employer filling the form in together

Section B: 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 and street	
Suburb/town	Postcode

7 Postal address

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

Number and street	
Suburb/town	Postcode

8 Contact details

Home telephone	Work telephone
Mobile number	
Email address	

9 What is the claim for?

☐ time off work (other than the day of the injury)

If your claim is accepted, you will need to complete a Tax file number declaration

☐ medical expenses

10 Worker's bank details

We pay claim and medical reimbursement payments by electronic funds transfer

Name of bank	
BSB number -	Account number
Account name	

Section C: Employment details

11 Employer's full company name and business address

Name	
Employer or RRTWC contact	
Number and 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

Section D: Injury details

14 When did the injury happen?

Date / / Time : ☐am ☐pm

15 What is the nature of the injury and part of the body that 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

Place	
Number and 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?

Name

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 certificate? / /
Diagnosis
Doctor's name
Practice/hospital name
Date first seen / /

Worker's capacity for work

☐ fit to return to normal duties from

Date / /

☐ fit for suitable duties (restricted hours) from

Date / / to / /
Restriction/s

☐ not able to work at all from

Date / / to / /

Treatment

☐ no further treatment required

☐ will require treatment from

Date / / to / /
Treatment required

Section E: Wages information

22 Worker's wages/salary

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

The normal weekly earnings calculator is available on our website at www.workcoverqld.com.au.

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

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

24 Has the employer excess been paid to the worker?

☐ no

☐ yes, gross amount paid $

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 -	Account number
Account name	

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

27 Reference code or payroll number for the worker

Important information—read before agreement

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

Section F: Privacy notice and statements

Privacy

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 your employer, 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.

Workers 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 consent to WorkCover Queensland communicating with all parties, including injured workers, employers, and medical and allied health providers by email.

I have read and understand the privacy notice.

Full name	
Date / /	☐ I agree

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 consent to WorkCover Queensland communicating with all parties, including injured workers, employers, and medical and allied health providers by email.

I have read and understand the privacy notice.

Full name	
Date / /	☐ I agree

What's 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 the claim, but we decide most claims within five days.

If the claim is accepted, it may be managed by one of our customer service centres to assist with return to work. If the claim is for time off work, the injured worker will be required to complete a *Tax file number declaration* and send it to us.

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