Print Form

Insurer Claim No.

To the Insurer (mandatory field must be completed)
Date claim form received ____ / ____ / ____
Date claimant notified ____ / ____ / ____
Accept/Reject/Defer Reason ____________

Claim Number

1. About you

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Surname or Family Name

First or Given Names

Other names you have been known by eg maiden name, previous married or defacto name.

Sex: Male ☐ Female ☐

Residential Address

Postcode

Postal Address

Postcode

If you change your address after lodging your claim contact NT WorkSafe immediately to ensure timely notification of the decision on your claim.

- Telephone No. Home
  Work
- Date of Birth / / Age
- Country of Birth
- Language spoken at home
- Marital status Single ☐ Married ☐ De facto ☐
- Worker's dependants Spouse ☐ Children ☐

Other dependants (please specify)

2. About your job

Your occupation at the time of injury/disease.
Include here the main job you do and your job title.

- Are you an Apprentice/Trainee? No ☐ Yes ☐
- Do you work Full time ☐ Part time ☐
- Are you Permanent ☐ Temporary ☐ Casual ☐
- **Do you have other paid employment?** No ☐ Yes ☐

If yes give details:
Full name and address of employer

3. About your claim

Where did the injury/disease occur? Please tick

A ☐ At the workplace at which I am normally based.
B ☐ Working elsewhere
C ☐ While I was having a break
D ☐ Travelling to or from work
F ☐ Attending training school
J ☐ Travelling whilst on duty
☐ Other - give details below

Tell us the exact location or address where the injury/disease occurred.

When did your injury happen or you first noticed the disease?

Date / / Time am/pm

4. About the incident

Please tell us:

- What you were doing at the time.
- How the accident happened or what caused the disease.
- Include the object or substance that caused the accident eg grinder, drill etc.

5. About your injury/disease

Include here:

- Part of body affected
- Type of injury or disease eg fracture, burn etc.
- If more than one injury which is the most serious?

6. Previous employers

Could the injury/disease have been contracted in previous employment? No ☐ Yes ☐

Name of employer

Address

Period of employment From / / to / /

7. Witnesses

The name and address of any persons who were present at the time of injury

8. Other information

Did you report the injury or disease to your employer?

No ☐ Reason

Yes ☐

- Date injury/disease was reported / /
- Time injury/disease was reported am/pm

Name of the person you reported it to

Position in the company

Did you stop work because of your injury or disease?

No ☐ Yes ☐

- Date you stopped work / /
- Time you stopped work am/pm
- Time you started work on that shift am/pm

If you stopped, have you started back at work now?

No ☐ Yes ☐

Date you started back / /

Did you get medical treatment following your injury/disease?

No ☐ Yes ☐

Name and address of the doctor and/or health worker

Dates you were treated / / / /

Were you admitted to a hospital?

No ☐ Yes ☐

Name and address of hospital

Are you still receiving treatment?

No ☐ Yes ☐

Name of the person treating you

What are you claiming for?

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

☐ Medical expenses, surgical, rehabilitation, hospital expenses

If claiming for time off work you must provide an approved workers' compensation medical certificate or the claim will be invalid and not considered by the employer/insurer.

Have you suffered from a similar injury/disease before?

No ☐ Yes ☐

Name and address of the doctor who treated you

Type of injury/disease

When did the injury/disease occur / /

Have you claimed workers' compensation before?

No ☐ Yes ☐ *SEE NOTE 1 ON THE BACK*

If yes attach details as follows:

- When was the claim
- Who was your employer
- Who was the treating doctor

Declaration

I declare that the information I have shown in this form is true and correct and I have told you everything I know about the circumstances relating to my work related injury or disease.

SIGNATURE

Date handed to employer / /

If you are completing this form for the diseased or injured person give your name and address below.

A claim for weekly benefits for time off work must be accompanied by a copy of the approved medical certificate. IF THIS CERTIFICATE IS NOT ATTACHED, THE CLAIM FOR WEEKLY BENEFITS IS NOT VALID.

Authorisation for Medical and Personal Information

I consent to my employer's insurer (or my employer if my employer is an approved self-insurer or the Northern Territory Government self-insurer) and it's appointed service providers collecting personal information about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability. I consent to the disclosure of my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. I also consent to the disclosure of my personal details to NT WorkSafe which is authorised to use this information to fulfil it's functions under the *Workers Rehabilitation and Compensation Act*.

I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and their insurer, and any rehabilitation provider appointed by the insurer.

I understand I cannot withdraw or revoke this authority.

I am willing that a photostat copy of this authorisation be accepted with the same authority as the original.

Print name in full — *Date*

Name ____________________ Signature ____________________ ____/____/____

NOTE: THIS AUTHORISATION MUST BE COMPLETED, OTHERWISE YOUR CLAIM WILL NOT BE CONSIDERED.

EMPLOYER'S REPORT ON INCIDENT (ALL SECTIONS MUST BE COMPLETED)

9. Employer information

Registered business name

What is your "trading name" if different from business name?

ABN

ACN (if applicable)

Address for correspondence

Telephone Fax

Name of the person who can be contacted in relation to this report

Position in the company

Date claim received from worker / /

10. Insurance details

What is your workers' compensation insurer's name?

What is the policy number?

What is the expiry date of the policy? / /

11. About the injured or diseased worker

What was the worker's gross weekly wage before the injury or disease?

$

Does this amount include any allowances? If yes attach details.

No ☐ Yes ☐

How many hours does the worker normally work each week?

hrs

Does the worker normally work overtime or shiftwork?

No ☐ Yes ☐

SEE NOTES 2 & 3 ON THE BACK

Where within your establishment does the worker normally work? NOTE: Your answer here must tell us the actual section and ADDRESS of the workplace where the worker does the majority of his or her work. If the worker works at multiple locations, tell us where the worker is normally based.

How many people are employed at this particular location? (ie, at the address above, at the present time)

1 - 4	☐	50 - 99	☐
5 - 9	☐	100 - 199	☐
10 - 19	☐	200 - 499	☐
20 - 49	☐	500 +	☐

When was the worker first employed by you?

/ /

Has the worker provided you with an Australian Business Number (ABN) in writing?

No ☐ Yes ☐

If yes, what is the worker's ABN?

Give details of other circumstances which would assist the insurer to assess the claim (eg Do you query the validity of the claim?)

No ☐ Yes ☐

In my opinion

What is the type of industry at the establishment where the worker normally works?

SEE NOTE 4 ON THE BACK

12. More than one person injured

Was more than one person injured in the incident described in Section 4? No ☐ Yes ☐

Please describe what happened, including the date and address where this happened.

13. Reportable accident?

Was this incident reported to NT WorkSafe as a notifiable accident?

No ☐ Yes ☐

SEE NOTE 5 ON THE BACK

If yes, date notified: / /

Declaration

I declare that all the information I have provided in this report is true and correct and I have told you everything I know about the circumstances surrounding this worker's injury or disease.

Signature Date / /

Name of the person who has filled in this form

Position in the company

INFORMATION FOR THE INJURED WORKER

(Important: remove this blue copy and keep this information for your records for the duration of your claim)

WHAT ARE YOUR ENTITLEMENTS

Once your claim has been **accepted** your employer is required to pay:

- **Weekly payments** – may commence within 3 working days of the insurer accepting the claim. A worker is entitled to receive their normal weekly earnings for the first twenty-six (26) weeks of total or partial incapacity.
- If after the first 26 weeks you are totally or partially incapacitated you will normally be paid at 75% of your loss of earning capacity. Minimum and maximum provisions may apply.
- **Medical expenses** – reasonable hospital, medical and ancillary expenses resulting from your work related injury.
- **Vocational rehabilitation expenses** – if specialist services are required to help your return to work, an approved vocational rehabilitation provider will assess your situation and provide assistance if appropriate.
- **Travelling expenses** – reasonable travelling and accommodation expenses incurred while obtaining medical treatment.
- **Other services -** The provision of home modifications, vehicle modifications and household and attendant care services as are reasonable and necessary.
- **Permanent Impairment –** If you are left with a permanent impairment as a result of a work related injury or illness there is provision under the *Workers Rehabilitation and Compensation Act* for a payment in respect of that permanent impairment.
- For more detailed information refer to Information Bulletin 13.01.16. (www.worksafe.nt.gov.au)

HOW TO MAINTAIN YOUR CLAIM

- **Regular contact** – between you, your doctor and your employer/insurer is important and will assist the overall management of your claim.
- **Ensure** – you provide your employer with all medical certificates from your treating doctor as quickly as possible. You should keep a copy for your records.
- **Discuss** – any concerns you have with your employer, insurer, doctor or NT WorkSafe.
- **Your employer** – and doctor may discuss your injury and your return to work options.
- **Medical Treatment –** Where practicable, appointments should be made outside working hours. Any time loss in a week (during working hours) counts as a full week, towards the 26 weeks total.

YOUR RETURN TO WORK

- You must cooperate with reasonable treatment, rehabilitation and return to work programs.
- Your employer should take all reasonable steps to provide you with suitable employment. However, if your employer is unable to provide suitable duties they, in consultation with the insurer, must refer you to the alternative employer incentive scheme to assist you in gaining suitable alternative employment. For more information refer to the Information Bulletin 13.02.08.
- You are also required to inform your employer if you commence employment elsewhere, or circumstances change in a way which may affect your entitlements.

DISPUTES

- Should you disagree with any decision made by the insurer regarding your workers' compensation claim, contact NT WorkSafe for information on dispute resolution procedures by phoning 1800 250 713, or visit our website at www.worksafe.nt.gov.au.

NOTES ON CLAIM FORM

FOR THE WORKER

NOTE 1

This information is required to determine if the present injury or disease may be related to a previous incident.

FOR THE EMPLOYER

NOTE 2

If worker has no fixed hours and is employed on a casual basis, please state the average number of hours worked per week. If no fixed hourly rate of pay applies then the earnings over the same period must also be averaged. (Where possible, please provide a copy of previous pay sheet/slip to substantiate regular hours.)

NOTE 3

If a regular or fixed pattern of overtime and/or shifts are worked, you must confirm in writing the basis on which it is worked ie for how long has the worker been working these shifts and what is the regularity.

NB Do not let the provision of this information cause delay in giving this claim to your insurer. However, you will need to discuss these details, with your insurer, as soon as practicable after giving them the claim.

NOTE 4

You must state the main type of activity, business or service you provide in which the injured worker was involved. You do not put the actual occupation of the worker: eg if you are a gold mining company and the injured worker is a driver, put down 'gold mining'.

NOTE 5

Obligations to report notifiable incidents/accidents under the *Workplace Health and Safety Act*

If the work related injury or illness that forms the basis of this claim meets the criteria addressed in NT WorkSafe information bulletin 09.01.04 Notification of incidents (available on the website www.worksafe.nt.gov.au), it should have been reported to the Authority. Section 64 of the *Workplace Health and Safety Act* establishes the criteria for work related accidents/incidents and includes those requiring medical treatment be reported to the Authority. These must be reported to NT WorkSafe as soon as is practicable by phoning 1800 019 115. A written notification report of the incident, in an approved form (FM137), must also be provided to NT WorkSafe within 48 hours of its occurrence.

BENEFITS ARE:

Weekly benefits for incapacity, costs of medical treatment, reasonable rehabilitation costs, benefits for permanent impairment, and death benefits.

Government Printer of the Northern Territory

WORKERS COMPENSATION CLAIM FORM

and

EMPLOYER'S REPORT

WORKERS REHABILITATION AND COMPENSATION ACT

(Before giving this claim form to your employer, remove the blue copy and retain for your records)

To the Worker

HOW TO CLAIM

- The employer should be informed of a work-related injury or disease as soon as practicable. This can be done either verbally or in writing.
- You may see a doctor of your choice. If the claim is for lost time, ask your doctor for a Northern Territory workers' compensation medical certificate and attach a copy to the claim form. If this certificate is not attached, the claim is not valid. If you are not claiming for time off work, you need only to provide a standard account or receipt with the claim form.
- Fill in the first 2 pages of the workers' compensation claim form and submit it with all relevant documentation attached, to your employer. Retain the blue copy of this form for your records. Note: You have up to 6 months to lodge your claim on your employer. However, it may be in your best interest to lodge it as soon as practicable.
- In some circumstances a claim can be made after 6 months.
- If you can't fill in this form yourself you may ask someone else to help you.
- Once you have given your claim to your employer, your employer must complete page three and send it to their insurer.
- The insurer will make a decision on the claim within 10 working days of the employer receiving it and advise you (in writing) if your claim is accepted, rejected or deferred. For further information on the process see NT WorkSafe Information Bulletin 13.01.16. This can be found on NT WorkSafe website at www.worksafe.nt.gov.au.

Note: For further information see **(INFORMATION FOR THE INJURED WORKER)** section of this form.

To the Employer

- Make sure a separate form is filled in for each injured or ill worker.
- Ensure the worker completes this claim form. If the worker is unable to complete this form please arrange for the form to be completed on their behalf.
- **Send the original and white copy of this form to your insurance company immediately (there may be a penalty if there is a delay of more than 3 working days).**
- Make sure the copy of the worker's medical certificate is included (where applicable).
- Keep the yellow copy for your records.
- If a worker has died, do not fill in this form, please contact NT WorkSafe.
- Send other medical certificates and accounts to your insurer as they become available.
- If the claim is accepted and it involves lost time, then you should commence weekly payments to the worker within three (3) working days of the claim being accepted.
- If the insurer defers liability, weekly payments of compensation must commence within three (3) working days of that decision. These payments are to commence with one weeks pay and continue for up to 8 weeks within which time the insurer will either accept or reject liability. If the claim is accepted, compensation owing must be offset by any amounts paid during the period of deferral. If the claim is rejected the deferral payment will cease. This payment is not recoverable from the injured worker.
- You must take all reasonable steps to provide the injured worker with suitable employment, and when necessary, so far as is practicable, participate in efforts to retrain the worker.
- If the employer is unable to provide the worker with suitable employment they, in consultation with the insurer, must refer the worker to the alternative employer incentive scheme.

Help

You can get help and more information from

NT WorkSafe
First Floor Darwin Plaza Building
41 Smith Street, The Mall
Darwin NT 0800
Ph: (08) 8999 5585

NT WorkSafe
Peter Sitzler Building
67 North Stuart Highway
Alice Springs NT 0870
Ph: (08) 8951 8682

NT WorkSafe
Ground Floor, NTG Centre
First Street
Katherine NT 0850
Ph: (08) 8973 8416

Australia wide (toll free number) – 1800 250 713

Website – www.worksafe.nt.gov.au

Email: ntworksafe@nt.gov.au