



Australian Government

Comcare

PUTTING YOU *FIRST*

CLAIM FOR INCAPACITY FOR WORK/RECORD OF EARNINGS STATEMENT OF WEEKLY HOURS WORKED IN SELF-EMPLOYMENT

IMPORTANT NOTES – PLEASE READ CAREFULLY! Failure to properly provide the required information may result in your payments being delayed while clarification is sought.

In calculating your compensation payments for any period that you claim your work capacity was restricted by your compensable injury, Comcare must take into your **'actual earnings'**.

'Actual earnings' is the amount of income that you earned in self-employment or any other paid employment.

Comcare **must** calculate your compensation payment **week by week** on a full **7 day week** basis,

For self-employment, Comcare calculates your actual earnings based on the number of **hours and minutes** you worked and the hourly 'value' of your labour. You should have received separate advice from Comcare regarding the assessment of that hourly labour value.

Please note that Comcare is concerned only with the hours that you worked in a week, not when you were paid for them.

You must **not** complete this form before you have actually worked the days indicated.

- > Fax this form to 1300 196 971 OR Post to Comcare, GPO Box 9905, Canberra ACT 2601.
- > Please ensure the form is marked to the attention of your current Claims Services Officer. Your CSO's name can be obtained by calling Comcare on 1300 366 979.
- > Current medical certification of restricted work capacity must be available to cover any period claimed. Suitable medical certificates can be obtained from Comcare or your doctor may have them available. Comcare will notify you when you are required to forward a certificate.

If your employment situation changes or if you do not intend to undertake further employment, please contact your CSO as soon as possible.

CLAIMANT TO COMPLETE:

Your Comcare claims services officer's name

Comcare

claim number

Your name

Your phone (bus hours)

Brief job description (task/duties)

ALL sections MUST be FULLY completed, including SATURDAY and SUNDAY. Do NOT leave any spaces BLANK.
 ENTER '0' IF NOT WORKING. Do NOT use DECIMAL Hours/Mins.

	DAY								
Week 1	DATE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	TOTAL hours and minutes
	HRS : MINS	:	:	:	:	:	:	:	:
Week 2	DATE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	TOTAL hours and minutes
	HRS : MINS	:	:	:	:	:	:	:	:

I claim the above periods of partial or total incapacity for work are attributable to my compensable injury and affirm that the information provided on this form and in any attachments is correct and accurately reflects my hours worked for the weeks indicated. I am aware that the intentional provision of false, misleading or incomplete information may result in a recoverable overpayment and may be a criminal offence.

Signature Date

PLEASE NOTE: FAILURE TO COMPLETE THIS FORM PROPERLY MAY RESULT IN DELAYED PAYMENTS!