



Claim for Workers' Compensation

This form is to be completed if you wish to claim workers' compensation under the Safety, Rehabilitation and Compensation Act 1988 (SRC Act). Key features of the scheme are explained on the back of this form.

The form is in two parts. **Part one** is for you to complete. **Part two is for your supervisor and personnel area** to complete. Once the questions in both parts have been answered, your employer must lodge the form with Comcare.

The sooner you complete and submit this form, the sooner your claim can be processed.

Assistance to return to work – your responsibilities

- Find out about your agency's rehabilitation policy;
- ensure you let your supervisor and if relevant, the person in your agency who will be assisting you with your return to work (case manager) know if you are going to be away from work for an extended period (ie. greater than 5 days) due to a work related injury;
- you may need to undergo an assessment for rehabilitation;
- talk to your case manager about your obligations and rights regarding rehabilitation and return to work;
- actively participate in the return to work program; and
- talk to your case manager or rehabilitation provider whose services have been secured to assist your return to work if you have any concerns about any rehabilitation program (return to work plan) developed for you.

If a rehabilitation program is developed to assist your return to work you must undertake the program as set out in the written return to work plan.

If you need support or assistance to return to work, please speak with your supervisor or agency case manager. For more information about rehabilitation visit www.comcare.gov.au

Privacy and personal information

Comcare needs to collect personal information about you to determine your entitlement to compensation and to perform other functions required by the SRC Act.

In the course of managing your claim, Comcare may need to disclose your personal information to the following third parties:

your employer, medical practitioners and other health professionals, rehabilitation service providers, legal advisers and law enforcement authorities, and other government entities where there are obligations under law to do so.

In the course of managing your claim, Comcare, your employer, medical practitioners and other health professionals, rehabilitation service providers, legal advisers and law enforcement authorities, and other government entities where there are obligations under law to do so, may have occasion to disclose your personal information to each other.

For more information call **1300 366 979** or visit our website at www.comcare.gov.au

How to claim workers' compensation

Fill in this form

Please complete using **black or blue ink** in answering the questions in **Part 1** of this form.

Not all of the questions in Part 1 of this form will apply to you. If a question does not apply to you or your circumstances, write N/A in the space provided.

If your answers do not fit in the space provided, please attach additional pages with the details.

If your circumstances are reasonably **simple** and you have information readily at hand, you should be able to complete this form in **less than 25 minutes**.

Once you have filled in Part 1 of this form and attached all the documents you need to support your claim, you must **sign the declaration** on page 9.

If you were not employed by the Australian or ACT government at the time you were injured or contracted your illness, you **may not have an entitlement** to workers' compensation under the SRC Act. If you are unsure, please call Comcare on 1300 366 979.

Collect all the documents you need

You will need to provide an **original medical certificate** stating that you have a work-related injury or illness. The certificate must state a precise medical diagnosis.

If you are claiming for chiropractic, physiotherapy or osteopathic **treatment only** and not for payment for any time you have taken off work, you will need only to provide an original certificate from your treating chiropractor, physiotherapist or osteopath.

In all other cases, you will need to provide an **original medical certificate** from a legally qualified medical practitioner (for example a general practitioner or medical specialist).

If you are claiming for an illness or disease, your medical practitioner will also need to provide information that indicates how your employment with the Australian or ACT governments contributed to your medical condition.

The form will also tell you which other documents or information you will need to provide to support your claim.

Use the checklist at the end of Part 1 of this form to make sure you have provided all the required information.

Lodge this form

Provide this form and attachments to your supervisor.

Your employer needs to complete **Part 2** of this form.

If you are no longer employed, you must provide this form to the employer for whom you worked when you were injured or contracted your illness. In some cases, the employing department or organisation may no longer exist or may have changed its name. If this is the case, please call Comcare on 1300 366 979.

When Part 2 of this form has been completed, the form and attachments will be sent to Comcare. Comcare will write to you to let you know the claim has been received and will advise you in writing of any decisions made on your claim.

Do you need help with this form?

If you need assistance to complete this form, call Comcare on 1300 366 979 (for the cost of a local call). If you need translating or interpreting assistance, please call 13 14 50.



About You

1. What is your full name? Title: Mr Mrs Ms Other

Surname:

Given name(s):

2. Do you have, or have you ever had, any other name(s)? No

Yes

For example: maiden name or previous married name.

What name(s)?

3. Are you: Male Female

4. When were you born? / /

5. How can we contact you during the day?

Home telephone number

Work telephone number ()

Mobile phone number ()

6. Do you have a preferred language other than English? No

Yes

What language?

Do you need an interpreter? No

Yes

Call the Translating and Interpreting Service on 13 14 50

7. Where do you live?

Your permanent home address

(please give street address and not a PO Box)

State Postcode

8. Do you have a different postal address? No

Yes

Please give details:

9. Do you need another person to act on your behalf for this claim? No

Yes

For example: a partner, support person or solicitor.

Please give details:

Their name

Their daytime telephone number ()

Postal address

About your injury or illness

10. For what injury or illness are you claiming workers' compensation?

Diagnosed condition:

Quote the precise diagnosis as stated on a medical certificate.

For example: diagnosed conditions **are**: disc prolapse, strained cruciate ligament and anxiety disorder, and they **are not**: back pain, sore knee and stress.



Please attach ORIGINAL certificates detailing your work-related injury or illness.

11. What part(s) of your body has been most affected by your injury or illness?

Part(s) of body injured:

For example: right knee, upper left arm, lower back, neck, respiratory system, mental state.

12. When were you injured or when did you first notice you were ill?

Date:

 / /

Time:

 am/pm

Give approximate time if exact time is not known.

13. When and where did you first seek medical treatment for your injury or illness?

Date:

 / /

Telephone number:

 ()

14. Have you been referred to a specialist or for any diagnostic tests for your injury or illness?

No

Yes



Who were you referred to and why?

Name of specialist:

Address of specialist:

State

Postcode

Telephone number:

Nature of referral:

(For example: X rays)



If you were referred to more than one specialist, please attach details.

15. Have you undertaken any of the following treatments for your claimed condition?

Tick any relevant boxes

Physiotherapy

Chiropractor

Hospital treatment

Pharmaceuticals

Counselling

Other (please specify)

16. Have you ever had a similar symptom, injury or illness, work-related or otherwise?

No

Go to Question 19

Yes

Describe the symptom, injury or illness and the parts of the body affected. Give approximate dates.

17. Have you ever received medical treatment for a similar injury or illness?

No

Yes

Please give details:

Date

Name of doctor

Telephone number ()

18. Have you ever claimed workers' compensation for a similar injury or illness?

No

Yes

Please give details:

Please answer this question even if the claim was not accepted.

Year claimed

Name of insurer

Name of employer at the time

Claim reference number (if known)

19. How long do you expect to be absent from your workplace due to your injury or illness?

No absence

Less than 1 week

Less than 12 weeks

Longer than 3 months

About how you were injured or became ill

20. Who was your employer when you were injured or became ill?

Name of employer:

For example: the name of your department or agency.

21. When you were injured or became ill, were you employed anywhere else (including in self employment, voluntary and/or unpaid work)?

No

Yes

Please give details:

Name of employer:

Address of employer:

State Postcode

How many hours did you work for the other employer? per week

How much did you earn? per week

 If you were employed by more than one employer, please attach details.

22. Where were you when you were injured or contracted your illness?

Tick one box only.

Working at my usual workplace

Working somewhere else

On a break

Working at home

Engaged in a sporting activity

Attending an approved course of study

Transport accident while working

▶ You will need to complete the supplementary claim form (p 11 - 14)

Travelling to or from work

▶ You will need to complete the supplementary claim form (p 11 - 14)

If other, please give details

23. What is the address at which you were injured or contracted your illness?

Street address:

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State

Postcode

Location:

(For example: at my desk, on the fire stairs, in the machine shop, on the basketball court.)

24. What were you doing at the time you were injured or contracted your illness?

ie: What started the chain of events that led to your injury or illness?

25. What action, exposure or event happened to cause your injury or illness?

For example: I slipped on the floor, I lifted a box.

26. What actually injured you, or made you ill?

For example: a car, the floor, a computer keyboard, a person, a stairway, a box.

27. At the time you were injured / became ill, were you under the influence of alcohol or other drugs including prescribed medication?

No

Yes

▶ Please give details

28. Was there a witness to your injury?

No

Yes

Please give details:

Name of witness

Telephone number

()



If there was more than one witness to your injury, please attach details.

Please note that witnesses may be asked to provide a statement in some circumstances. Please attach a witness statement if you feel that it would assist in determining liability for your claim.

29. Was someone else responsible for your injury or illness?

No

Yes

Please give details:

What is their name?

Telephone number

()

30. Do you intend to take action, other than making this claim, to recover personal injury damages or expenses from either the government or a third party?

No

Yes

Do you have a solicitor acting on your behalf?

No

Yes

Please give details:

Name of solicitor

Telephone number

()

You must inform Comcare in writing when initiating a claim against the government or a third party in respect of your injury or illness. Failure to notify Comcare within 7 days of initiating proceedings may result in a penalty.

31. Did your injury or illness happen, while you were travelling?

No

Yes

Go to Question 35

Go to Question 32

You will also need to complete the supplementary claim form (p 11 - 14) for injuries which occurred while travelling.

About your journey

32. How were you travelling on your journey?

For example: driving a car, passenger on a train, boat or aircraft, cycling, walking.

33. When was the journey?

During working hours

Before or after work

While on a break

34. Have the police been notified?

No

Yes

Please complete the attached supplementary claim form (p 11 - 14) for injuries that occurred while travelling.

Checklist

Please use this Checklist as a guide to check that you have completed this form and have attached all necessary attachments before signing and giving it to your employer.

Check that you have answered all the questions you are required to answer.



Medical information (question 10)

Have you **attached an ORIGINAL medical certificate from a legally qualified medical practitioner?**

(For example, a general practitioner or medical specialist.)

OR

If you are claiming for chiropractic, physiotherapy or osteopathic **treatment only** and not for **time off work**, have you attached an original certificate from your treating chiropractor, physiotherapist or osteopath?

If you are claiming for an illness or disease, have you attached information from your medical practitioner that indicates how your employment with the Australian or ACT government contributed to your medical condition?



Additional information

If you were referred to more than one specialist (question 14), have you **attached details of the other specialist(s)?**

If you were employed by more than one employer (question 21), have you **attached details of the other employer(s)?**

If there was more than one witness to your injury (question 28), have you **attached details of the other witness(es)?**

If your injury occurred as a result of a transport accident or while travelling to / from work (question 22), have you completed the **“Supplementary Claim for Injuries that occur whilst on a journey” (page 11-14).**

If this claim is not for a transport / travel claim please remove and discard pages 11- 14.

If you would like Comcare to arrange for your medical expense reimbursement payments to be paid by EFT into your bank account have you completed the **“Electronic Funds Transfer (EFT) request” (page 10).**

Please read and sign the authorisation and declaration on the next page, and provide the signed original and attachments **to your supervisor.** Step 3 on page 2 will give you more information about the lodgement process.

Authorisation and declaration

35. Please read and sign this authorisation and declaration.

I authorise and consent to Comcare collecting my personal information from or disclosing my personal information to:

- my employer;
- my health professional or other health institution;
- my case manager;
- my rehabilitation provider; and
- any other relevant third party (or insurer) considered by Comcare to have contributed to the injury;

for the purposes of determining and managing my compensation claim and/or assessing my suitability to undertake a rehabilitation program and/or to assist Comcare in any actions authorised under the SRC Act.

I authorise and consent to any health professional, hospital or other health institution, my employer, my case manager, my rehabilitation provider and any third party (or its insurer) considered by Comcare to be relevant to the management of my compensation claim, collecting my personal information from or disclosing or releasing records containing my personal information, or discussing with or providing information about me, to one another.

I understand that the information is required for the purposes of determining and managing my compensation claim and/or assessing my suitability to undertake a rehabilitation program and/or to assist Comcare in any actions authorised under the SRC Act.

I also authorise and consent to my superannuation fund manager or trustee discussing with, or providing information to Comcare and my employer any information concerning my superannuation entitlements.

I further authorise and consent to a photocopy of this Authority and Consent as sufficient evidence of my authority and consent to discuss or provide the information requested.

I declare that:

the information I have supplied on this form and any other attachment is true and accurate;

- I am aware that I must advise Comcare immediately if I engage in any employment, whether paid or not, or in the running of a business in my own right or as a partner during the period I am absent from work as a result of this injury/disease;
- I am aware that I must advise Comcare if my injury or disease improves during any period of incapacity sufficiently to allow me to return to work;
- I am aware that the making of a false or misleading claim or false or misleading statement in support of that claim is punishable by law under the Criminal Code Act 1995 and, in that event, I may be liable for prosecution;
- I am aware that any monies paid by Comcare as a result of a false or misleading statement or claim will be recovered.

Print your name:

Your signature:

Date:

What to do now

Make a copy of this form and attachments for your records.

Provide the signed original and attachments to your supervisor. Step 3 on page 2 will give you more information about the lodgement process.

If the department or organisation no longer exists, or has changed its name, see page 2.

Electronic Funds Transfer (EFT) Request:

Comcare is currently utilising an Electronic Funds Transfer process (EFT) to enable the reimbursement of claimants' medical expenses to be paid directly into their bank accounts. The advantages of this method of payment are that claimants receive their payments quicker as they do not have to wait for a cheque through the mail, or wait for the cheque to be cleared; money can be accessed through automated teller machines at any time instead of having to go to the bank; and claimants do not have to worry about payments being sent to the wrong address, being lost in the mail or stolen from mail boxes.

Please complete the following section if you want Comcare to arrange for your payments to be paid by EFT directly into a bank account. If you do not wish for payments to be paid by EFT, leave this section blank.

Name of Institution:

Branch Address:

State

Postcode

Account Name:

BSB Number:

Account Number:

Declaration:

By signing this form, I certify that:

a) I am authorising Comcare to pay **medical payments** direct into my nominated bank account and that the bank details I have provided are correct.

Print your name:

Your signature:

Date:

Note: If your EFT payment fails, all your subsequent payments will be made by cheque, until Comcare receives your correct bank details.



About the employee

Surname:

Given Name:

Date of birth:

Address:

Employer:

Comcare claim
number (if known) :

About the journey

1. What were your hours
of duty on the day of
the journey?

From:

To:

2. From where were you
travelling?

Workplace

Home

Other

▶ Please specify

3. To where were you
travelling?

Workplace

Home

Other

▶ Please specify

4. Approximately, what time
did you leave?

am / pm

About the accident

5. Has the accident been reported to the police?

No

Yes



If yes, please advise the location of the Police station and the Police Incident number, if applicable.

6. Date the accident was reported:

	/		/	
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7. Police officer's name:

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8. Did police attend the scene of the accident:

No

Yes

9. Has any police action been taken or is it proposed?

No

Yes



If yes please provide details?

10. Was a seatbelt provided?

No

Yes

11. If yes, were you wearing a seatbelt?

No

Yes

12. If you were riding a bicycle were you wearing a helmet?

No

Yes

About the Vehicle in which you were travelling

Registration Number:

State of Registration:

Driver's Name:

Address:

State

Postcode

Telephone number:

Owner's Name:

Address:

State

Postcode

Telephone number:

Other Vehicles involved

Registration Number:

State of Registration:

Driver's Name:

Address:

State

Postcode

Telephone number:

Owner's Name:

Address:

State

Postcode

Telephone number:

Declaration of Employee

I declare that all information provided on this form is true and accurate to the best of my knowledge.

Print your name:

Your signature:

Date:



This part of the form is in two sections:

- Section one asks questions that the applicant's supervisor and/or agency officer responsible for managing this claim (case manager) should be able to answer, and
- Section two asks questions that an agency's personnel area should be able to answer.

The completed claim form should be sent to Comcare within 5 days of its receipt by the employer.

Supervisor and/or agency case manager to complete

1. What date did you receive this claim from the employee?	Date claim first received by employer (Manager, Supervisor, Human Resources etc)	<input type="text" value="/"/>	<input type="text" value="/"/>
2. When did the employee first notify the employer (for example, their supervisor) of the injury or illness?	Date injury/illness notified to the employer:	<input type="text" value="/"/>	<input type="text" value="/"/>
3. When the injury or illness happened, was the employee:	Voluntary (paid or unpaid)	<input type="checkbox"/>	
	Temporary (non-ongoing)	<input type="checkbox"/>	
	Permanent (ongoing)	<input type="checkbox"/>	
4. When the injury or illness happened, what was the employee's classification level?	Employee's Classification: For example: APS 4, EL2, SES1:	<input type="text"/>	
5. When did the employee commence employment with your agency?	Date:	<input type="text" value="/"/>	<input type="text" value="/"/>
6. How long had the employee been performing this role prior to the injury?	<input type="text"/>	Years	Months
7. Has the employee taken any time off work as a result of the injury/illness?	No	<input type="checkbox"/>	
	Yes	<input type="checkbox"/>	▶ Has the employee returned to work?
		No	<input type="checkbox"/>
		Yes	<input type="checkbox"/>
		<input type="text" value="/"/>	<input type="text" value="/"/>

Have they returned to:

• their pre-injury working hours

OR

• less than their pre-injury working hours

▶ Please specify:

(for example, on a graduated return to work program)

Hours

Please attach details of any leave taken since the injury or illness happened.

8. When the injury or illness occurred was the employee:
- An Apprentice
- A Trainee
- Neither

9. When the injury or illness happened, what was the employee's job title and main duties? (Please include travel if part of normal duties)

Employee's job title:

Employee's main duties:

10. What action has the employer taken to return the employee to work or prevent further injury?

Tick as many as appropriate.

Employers have a statutory responsibility under Part III of the SRC Act for the rehabilitation of employees with work-related injuries and must take all reasonable steps to assist the employee to find suitable work where a return to normal duties is not possible. An employer may refer the injured employee for a rehabilitation assessment (s36) and may make a decision (s37) that this employee should undergo a rehabilitation program which may involve a rehabilitation provider. The rehabilitation provider's role is to assist the employer to achieve an early and safe return to work for its injured/ill employee.

Contacted the employee to determine the support they need to return to work

Discussed return to work options with the employee and/or their doctor

Arranged an assessment of the employee's workplace, workstation or work task requirements

Offered alternate or modified duties or working arrangements

Arranged an assessment of the employee's capability to undertake a rehabilitation program (return to work program)

under s36

or as part of the agency's injury management policy

Developed a RTW plan (rehabilitation program) under s37 of the SRC Act provided by:

Rehabilitation authority

Approved rehabilitation provider

Implemented a rehabilitation program

Other (please give details)

11. Are you aware of any physical, psychosocial or workplace barriers that may delay the employee's timely return to work?

No **Go to Question 12**

Yes **Please give details**

The SRC Act provides a 'no fault' workers' compensation scheme. This means that in general, Comcare does not need to consider who is at fault in causing a work-related injury or illness. However, some exclusionary provisions do apply, such as reasonable administrative action.

If you believe that there are additional circumstances relevant to the injury or illness claimed, or you wish to provide additional facts for Comcare to consider in determining this claim, please attach a signed and dated statement or provide details of an intended submission date. If you are unsure what to include in a statement of facts, or you want a list of the exclusionary provisions, please visit <http://www.comcare.gov.au> or call Comcare on 1300 366 979.

12. Do you wish to provide a statement of facts?

Yes Statement is attached.

Yes Statement will be forwarded to Comcare.

(If you do not provide Comcare with a statement of facts, a determination on the claim may be made on the evidence at hand.)

Personnel area to complete

13. When the injury or illness happened, what department or authority was the employee's employer and what is the liable cost centre number for this employer ?

Name of employer:

Address of employer:

State

Postcode

A cost centre number must be provided. For information on cost centre numbers, call 1300 366 979.

Cost centre number:

14. Your reference number for this claim or employee?

Reference number:

15. What was the employee's payroll or AGS number?

Payroll/AGS number:

16. When the injury/illness happened, what were the employee's standard working hours per week?

36hrs 45mins

38hrs

40hrs

Other (please specify)

Hours

Minutes

17. What department/authority is the employee's current employer and what is that employer's payroll cost centre number?

Name of employer:

Address of employer:

State

Postcode

If the employer is the same as indicated at Question 18, write 'as above'.

Cost centre number:

18. Name of the case manager and alternative contact for this claim?

Name of case manager:

Telephone number:


Name of alternative contact:

Telephone number: ()

19. If the person claiming compensation is no longer employed by the Australian or ACT government, how did their employment end?

Accepted voluntary redundancy Involuntary redundancy

Retired invalidity Resigned

Terminated  What was the date of effect? / /

20. What is the main type of work conducted at the address where the injury happened?

Main type of work:

For example: legal and accounting services, scientific research, defence, computer services.

21. When the employee was injured or became ill, were they temporarily absent from their usual place of work?

No  **Go to Question 23**

Yes  **Go to Question 22**


22. Was the activity undertaken during this absence either at your Agency's request or direction, or associated with their employment?

No

Yes

23. Was the employee's injury/illness as a result of administrative action undertaken by your Agency?

No

Yes  **Please provide a statement of facts as per Question 12**

24. When the injury/illness happened, what were the employee's gross normal weekly earnings?

Payment type	Normal weekly earnings
Base salary	<input type="text"/>
Overtime (see Question 25)	<input type="text"/>
Shift penalties	<input type="text"/>
Higher duties allowance (see Question 26)	<input type="text"/>
Other allowance(s) (see Question 27)	<input type="text"/>
Total	<input type="text"/>

Normal weekly earnings (NWE) take into account the employee's weekly salary payments for a relevant period (usually 2 – 12 weeks prior to the date of injury) and may include any overtime that was both **regular and required** during that period, and any shift penalties and allowances normally available to that employee. For more information on NWE, call **1300 366 979**.

25. If overtime has been included in the Normal Weekly Earnings total, what are the average weekly hours of that overtime? Average weekly hours of overtime:

26. If higher duties allowance has been included in the Normal Weekly Earnings total, what was the expected end date for the period of higher duties? End date of higher duties:

27. Were other allowances included in the Normal Weekly Earnings total? No Yes What was the allowance for?

28. Is the person claiming compensation still employed by the Australian or ACT government? No Yes

Manager to sign

29. This form is to be signed by a manager with line management responsibility for the workplace at which the employee was working at the time the injury/illness occurred.

Name:

Position:

Telephone number: ()

Signature:

Date:

What to do now

Make a copy of this form and attachments for your records.

Forward the signed original and attachments to:

Comcare
GPO Box 9905
Canberra ACT 2601.

'No-fault' scheme

The scheme operates under 'no-fault' legislation. This means that an injured employee does not have to prove negligence on the part of his or her employer for his or her claim to be successful. For a guide on how Comcare determines claims made under the Safety, Rehabilitation and Compensation Act 1988 (SRC Act) visit <http://www.comcare.gov.au>.

Emphasis on rehabilitation and return to work

The SRC Act has a very strong focus on rehabilitation and return to work with an emphasis on returning the employee to their pre-injury duties wherever possible.

Employers are responsible for the rehabilitation of employees with work-related injuries and must take all reasonable steps to assist the employee to find suitable work where a return to normal duties is not possible. Employers may negotiate work placements and trials where an employee cannot return to their normal duties. Where necessary the employer may refer the injured employee to a rehabilitation provider (see section 36 and 37 of the SRC Act). The rehabilitation provider's role is not to treat the condition of the injured employee but to assist the employer to achieve an early and safe return to work for its injured/ill employee.

Limited access to lump sum payments through common law actions

Unlike other workers' compensation schemes there is limited access under the SRC Act to lump sum payments through common law except where:

- the employee has been assessed by Comcare or a self-insurer as having a permanent impairment of 10% or greater for the whole person; and
- the employee has elected to sue for damages for non-economic loss as an alternative to statutory benefits; or where
- actions for damages are instituted by dependants of an employee who has died as a result of a work-related injury or disease.

Statutory benefits

The SRC Act provides where an injury/illness is work related, a comprehensive benefit structure with incapacity payments for time off work or reduced earnings. Employers are financially accountable for the cost of work-related injury and disease through payment of an annual premium to Comcare or through self insurance. Benefits may be payable until age 65 (or in certain cases for up to two years beyond this).

Benefits include:

- fortnightly/weekly payments based on the employee's normal salary
- all reasonable medical expenses.