CLAIM FORM FOR WORKERS COMPENSATION

Information for **Workers** – Guidance to PART 1 of the Claim Form

☐	Notify your employer of your injury, verbally or in writing, as soon as practicable.
☐	Fully complete PART 1 (questions 1 to 8) of the following claim form and make sure it is signed twice (in the Authorisation section AND in the Declaration section). The more information you provide on the form the quicker the claim can be progressed. If there is not enough space on the form to include the relevant information, please attach full details on separate page/s. Claims should be made within 6 months but in some circumstances a claim can be made after 6 months. If you are unable to fill in this form and someone else does it, they must provide their details on the form.
☐	Sign the **Declaration** AND the **Authorisation for Medical and Personal Information collection and disclosure** on the claim form (This means you are required to sign the form twice).
☐	You **must obtain and submit a Northern Territory Workers Compensation First Medical Certificate** with your claim form if you are claiming compensation for **loss of income**. You will need to get this from your doctor.
☐	Keep a copy of your Workers' Compensation Claim Form and any documents you have attached, for future reference.
☐	If you are claiming compensation for **medical expenses only**, you need **only** provide the relevant account/s or receipt/s with your claim form.
☐	Hand or post your claim form to your employer as soon as possible. If you are posting the claim form to your employer it is advisable to send it by registered mail.

WHAT NEXT:
Once you give the claim form to your employer, your employer must complete the Employer's Section PART 2, questions 9 to 13, and has 3 working days to submit the claim to the insurer. The insurer has 10 working days after the employer received the claim, to make a decision and notify you. The possible decisions are:

- Accept liability for the claim
- Defer accepting liability for the claim
- Dispute liability for the claim

The insurer will advise you of your rights and entitlements for the different types of decisions. If this doesn't happen you can request that they do so, or contact NT WorkSafe for information.

RETURN TO WORK
The purpose of workers compensation is to provide economic support while your employer assists you by providing suitable work or if necessary, retrains you. You are required to cooperate with reasonable medical, surgical and rehabilitation treatment and you must participate in the return to work process.

RESOURCES – INFORMATION BULLETINS:
These may be accessed on the NT WorkSafe website or telephone NT WorkSafe on 1800250713 to request a copy:

- Workers guide to workers compensation
- Eligibility for workers compensation
- A guide for temporary visa holders
- Guidelines for journey claims
- Return to work – a guide for workers
- Permanent impairment entitlement

THE ROLE OF NT WORKSAFE

The role of NT WorkSafe is to administer and enforce the *Workers Rehabilitation and Compensation Act.* NT WorkSafe provides a claims Mediation service and will arrange a medical panel for disputed Permanent Impairment assessments.

Claims are managed by approved insurers and self insurers. NT WorkSafe has no legislative power to review claims decisions made by insurers. This power rests with the Work Health Court.

DISPUTES
Should you disagree with any decision made by the insurer regarding your workers compensation claim, please contact the insurer for information on their Internal Dispute Resolution Process and /or contact NT WorkSafe for information on Mediation / dispute resolution procedures on 1800 250 713 or visit www.worksafe.nt.gov.au.

Information for **Employers** – Guidance to PART 2 of the Claim Form

☐	When you have received the claim form from your worker you must complete the Employer Section PART 2 (questions 9 to 13) of the claim form.
☐	Forward the claim form within 3 working days to your insurer, together with the Northern Territory Workers' Compensation First Medical Certificate (if applicable) and any other attached documents (e.g. medical receipts / accounts). If a decision as to liability for the claim is not made within 10 working days of you receiving the form, liability is deemed to be accepted.
☐	Retain a copy of the claim form and attached documents for your own future reference.
☐	If the injured or ill worker is unable to complete a claim form please arrange for a claim form to be completed on their behalf.
☐	If a worker has died due to a work related injury or disease, do not fill in this claim form, instead please contact NT WorkSafe on our toll free number 1800 250 713 (Australia wide).
☐	If liability is accepted or deferred, and there is time lost, payments must commence with 3 working days (your insurer will instruct you on this process). Subsequent payments should be made on normal paydays.
☐	Send other medical certificates and accounts to your insurer as they become available.

MORE INFORMATION ABOUT THE CLAIM PROCESS:
NT WorkSafe does not have a claims management role and employers should liaise with their insurer for information about the claims process and the calculation of weekly compensation. Insurers will provide employers with all the information needed to meet their obligations.

RETURN TO WORK
The employer 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. Refer to information bulletin Rehabilitation – A Guide for Employers.
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. Refer information bulletin Alternative Employer Incentive Scheme.

RESOURCES – INFORMATION BULLETINS:
These may be accessed on the NT WorkSafe website or telephone NT WorkSafe on 1800250713 to request a copy:

- Employers Guide to Workers Compensation
- Rehabilitation - A Guide for Employers
- Guidelines for journey claims
- Alternative Employer Incentive Scheme

EXPLANATORY NOTES FOR EMPLOYERS COMPLETING THIS FORM (see reference on the claim form)

NOTE 1
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 e.g. if you are a gold mining company and the injured worker is a driver, put down "gold mining".

NOTE 2
Obligation to notify incidents under the *Work Health and Safety (National Uniform Legislation) Act* – WHS Act. If the work related injury or illness that forms the basis of this claim meets the criteria addressed in NT WorkSafe information bulletin – Notification of Incidents (available on the website www.worksafe.nt.gov.au), it should have been reported to the Authority. Sections 35 and 36 of the WHS Act establishes the criteria for work-related serious injury and illness that must be notified to the Authority. These must be reported to NT WorkSafe immediately after becoming aware that a notifiable incident has occurred 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.

Contact NT WorkSafe
Toll free **1800 250 713** • Website www.worksafe.nt.gov.au • Email ntworksafe@nt.gov.au

NT WORKERS COMPENSATION CLAIM FORM

Insurer Claim No.	This panel MUST be completed by the Insurer	Claim Number
	Date Claim form received: .... / .... /	
	Date Worker notified: .... / .... /	
	☐ Accept / ☐ Deny / ☐ Defer	
	Reason:	

PART 1 – Workers Report on Injury / Disease

Worker to answer 1 to 8 on pages 1 and 2, and then forward to employer to complete questions 9 to 13 on page 3.

1. Worker details

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Last or Surname or Family Name:

First or Given Names:

Other names you have been known by e.g. maiden name, previous married or de facto name:

Sex: Male ☐ Female ☐

Residential address:

State: Postcode:

Postal address:

State: Postcode:

Work telephone: ( )

Mobile phone:

Home telephone: ( )

Email:

Date of birth: / / Age:

Country of birth:

Language spoken at home:

Marital status: Single ☐ Married ☐ De facto ☐

Dependants: Spouse? NO ☐ YES ☐

Children? NO ☐ If YES ☐ How many? Date/s of birth?

/ /	/ /	/ /	/ /	/ /

2. Workers job

Your occupation and job title at the time of injury/disease?

Are you an Apprentice / Trainee NO ☐ YES ☐

Do you work: Full time ☐ Part time ☐

Are you: Permanent ☐ Temporary ☐ Casual ☐

Do you have any other paid employment? NO ☐

If YES ☐ Give full name and address of employer:

State: Postcode:

3. About the 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

Exact location or address the injury / disease occurred:

When did your injury happen or you first become aware of the disease?

Date: / / Time: ☐ am ☐ pm

4. About the incident

What were you doing at the time?

How did the accident happen or what caused the disease?

Include the object or substance that caused the accident e.g. grinder, drill etc.

NOTE: If insufficient space, attach full details on a separate sheet.

5. About the injury / disease

Part of body affected:

Type of injury or disease e.g. fracture, burn etc.

If more than one injury which is the most serious?

NT WORKERS COMPENSATION CLAIM FORM

PART 1 continued – Workers Report on Injury / Disease

Worker to answer 1 to 8 on pages 1 and 2, and then forward to employer to complete questions 9 to 13 on page 3.

6. Witnesses

Name and contact details of any person who was present at the time of injury:

7. Other information

Did you report the injury / disease to your employer? NO ☐

Reason not reported:

If YES ☐ Date: / / Time: ☐am ☐pm

Name of person you reported it to:

Position in the company:

Did you stop work because of your injury or disease? NO ☐

If YES ☐ Date: / / Time: ☐am ☐pm

Time you started work that shift: Time: ☐am ☐pm

If you stopped, have you started back at work now? NO ☐

If YES ☐ Date started back: / /

Any medical treatment following your injury/disease? NO ☐

If YES ☐ Name and address of doctor and/or health worker:

Dates you were treated: / / / /

Were you admitted to hospital? NO ☐

If YES ☐ Name and address of hospital:

Are you still receiving treatment? NO ☐

If 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

NOTE: If claiming for time off work you must provide a copy of the **NT First Medical Certificate** or the Claim will be invalid and not considered by the employer/insurer

Have you suffered a similar injury/disease before? NO ☐

If 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 for the same or similar injury? NO ☐

If YES ☐ When was the claim made? / /

Employer name?

Treating doctor?

8. Previous employers

Could the injury/disease you have described in this claim have been contracted in previous employment? NO ☐

If YES ☐ Name of employer:

Employer suburb / town:

Period of employment:

Name of Insurer (if known):

Authorisation for Medical and Personal Information collection and disclosure

NOTE: This Authorisation must be signed otherwise your Claim will not be considered

I consent to my employer/employer's insurer and it's appointed service providers collecting personal information about me and using it for the purpose of assessing and managing this workers compensation claim, including determining liability.

I consent to the disclosure of my personal information to my employer/employer's insurer, 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 its functions under the Northern Territory *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/employer's insurer and any rehabilitation provider appointed by the insurer.

I understand I cannot withdraw or revoke this authority.

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

Name:

SIGNATURE:

Date: / /

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 / disease.

SIGNATURE:

NOTE: After you have answered questions 1 to 8 to the best of your ability on pages 1 and 2 of this Claim form, and signed both the **Authorisation** AND the **Declaration** above, please forward it to your employer to complete questions 9 to 13 on page 3.

Date that Claim Form forwarded to employer: / / ☐ By hand ☐ Posted

NOTE: A Claim for weekly benefits for time off work must be accompanied by a copy of the **NT First Medical Certificate**.

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

NT WORKERS COMPENSATION CLAIM FORM

PART 2 – Employers Report on Injury / Disease

Within 3 days the Employer is to complete the following questions 9 to 13 on this page (3) and forward to Insurer.

9. Employer information

Registered Business name:

What is the Trading name if different from above:

ABN:

ACN (if applicable):

Address for correspondence:

State: Postcode:

Phone: ( ) Fax: ( )

Email:

Name of person who can be contacted in relation to Claim:

Position in the business:

Date claim received from worker: / /

10. Employer information

What is your workers compensation Insurers name:

What is the policy number:

What is the expiry date of the policy: / /

11. About the injured or diseased worker

What was the workers gross weekly wage before the injury or disease: $

Does this amount include allowances? NO ☐ YES ☐
If YES, attach details

How many hours does the worker normally work each week? **hours**

Does the worker normally work overtime or shiftwork? NO ☐ YES ☐

Is the worker provided with any benefits, not paid by money or a credit, for accommodation, meals or electricity? NO ☐

If YES ☐ Market value to the worker: $

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 may people are employed at this particular location?
(i.e. at the address aforementioned, at the present time)

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

When was the worker first employed by you?
Date: / /

Is the worker a contractor? NO ☐ YES ☐

Did the contractor meet the results test for the work or supply a Personal Services Business Determination issued by the Australian Taxation Office? NO ☐ YES ☐

Is the worker temporarily in Australia on a visa? NO ☐
If YES ☐ Expiry date of visa: / /

Visa type:

Give details of other circumstances which would assist the insurer to assess the claim
(e.g. Do you query the validity of the claim?) NO ☐
If YES ☐ In my opinion:

What is the type of industry at the establishment where the worker normally works?
See NOTE 1 on page ii at the front of this form

12. More than one person injured

Was more than one person injured in the incident described at No. 4 on page 1 of this claim form? NO ☐
If YES ☐ Describe what happened, including the date and address where this happened.
NOTE: If insufficient space, attach full details on a separate sheet.

13. Notifiable incident?

Is this a notifiable incident that must be reported to NT WorkSafe? NO ☐
If YES ☐ Date notified: / /
See NOTE 2 on page ii at the front of this form

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 workers injury or disease.

Signature: Date: / /

Name of the person who has filled in this form:

Position in the business: