

COUNCIL CLAIM FORM (continued)
WAGES / AWARD INFORMATION

Is claimant a direct employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain	
Claimant is employed under: <input type="checkbox"/> Award / Salary System <input type="checkbox"/> Enterprise Agreement <input type="checkbox"/> Contract <input type="checkbox"/> Other (eg. Apprenticeship)	
Award/Agreement Title.....	Classification / Year of Apprenticeship:
Actual number of hours worked per week:	Base Award Rate per week: \$.....
Average no of hours worked per week:	Average Weekly Earnings \$..... (Last 12 months)
For Base Award Rate - EXCLUDE overtime, shift/penalty rates, allowances & other over-Award payments. For Average Weekly Earnings – INCLUDE overtime, shift/penalty rates, allowances & other over-Award payments.	

LIABILITY DETERMINATION

Are there any circumstances which you believe may influence determination of liability for this claim?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any other factors that may assist StateCover in managing this claim.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Would you like StateCover to contact you to discuss particular aspects of this claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIVACY

In accordance with the Privacy Act 1988 (and subsequent amendments), StateCover Mutual Limited draw your attention to the following:

- We may collect personal information about the claimant in connection with our services.
- We collect the information principally for the purpose of administering the claim.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, advisers and agents.
- By providing the information requested in this document the claimant agrees to us collecting, using and disclosing personal information as outlined in this Collection Statement.
- If the claimant does not provide all or part of the information requested, we may be unable to administer the claim.
- The claimant has the right to request access to, and correct, any personal information that we hold about him/her, subject to the provisions of the Privacy Act 1988.
- Our Privacy Policy can be made available on request.

EMPLOYER DECLARATION

I (print name and position)

declare that the details above are true and correct in every particular.

Signature of authorised person completing this form:

Date:

Has the claimant signed an Information Authority form? Yes No

Has the claimant been given a claim form? Yes No Date:

Important:

1. A Notice of Claim by the claimant must be forwarded to StateCover within **7 days of lodgement by the claimant**. This also applies to any future documentation / information received in respect of the claim.
2. Compensation payments may be made to the claimant within 7 days following discussion with StateCover, as long as a current medical certificate (in the form prescribed under the Act) has been provided by the claimant and liability is not in dispute.
3. All payments of weekly benefits will be made to Council unless special arrangements are made with StateCover.
4. If the claimant has not resumed work at time of lodgement of this claim, it is important to notify StateCover immediately when the claimant has been cleared for work or returns to work in any capacity.