

This form must be fully completed to properly make a claim for workers compensation in accordance with the legislation.

EMPLOYEE CLAIM FORM

To: _____ Council

Whilst in your employ I sustained the injury described below. I elect to claim under NSW Workers Compensation legislation.

PLEASE PRINT IN BLOCK LETTERS

CLAIMANT DETAILS

Title	Surname	Country of birth
Given name/s		Languages spoken
Current address		Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No
Suburb	State	Postcode
Date started in current position		
Telephone no. ()		<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/> Permanent <input type="checkbox"/> Shifts
Date of birth / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation / Position
Daytime Contact or Mobile No.		Supervisor's Name
Usual Days & Hours of Work		Supervisor's Contact no.

DEPENDENTS

Full name of dependent	Relationship to you	Date of birth	Full time student (yes / no)	Residing at home (yes / no)

OTHER CURRENT EMPLOYERS (including self-employment)

Do you have any other employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details:
Full name of Employer:
Address:

WHAT HAPPENED?

How did the injury occur, and what were you doing at the time? (eg. slipped while climbing a ladder.)
Workplace name / address where injury occurred (eg. works depot):
Suburb State Postcode
Name / address of any person who was present when the incident / injury happened:

INJURY DETAILS

When did the injury happen or when did you first notice the injury / disease? Date: / / Time: am / pm
To whom was the injury reported? Date notice given: / /
If you stopped work due to injury / disease – Date and time stopped work. Date: / / Time: am / pm
What injury(ies) / disease did you suffer? (eg. fracture)
What parts of the body were affected? (eg. right upper arm, lower back)



OTHER SIMILAR INJURIES

Have you previously suffered any similar injury or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details:
Date of previous injury / condition: / / to / / Was the injury / condition resolved? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, give details:
Name of employer (if applicable):

MEDICAL TREATMENT

Name of treating Doctor:	Phone no:
Name of Hospital (if applicable):	
WorkCover approved Medical Certificate attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: / /	

JOURNEY INJURIES

A separate "Journey" claim form must be completed in addition to this claim form. This is available from Council or direct from **StateCover**.

PRIVACY

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

- We may collect personal information about you in connection with our services.
- We collect the information principally for the purpose of managing your 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, and signing the Declaration below, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to determine or manage your claim.
- You have the right to request access to, and the correction of, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.

A copy of our Privacy Policy can be made available on request.

DECLARATION

I,hereby declare that the information I have provided in this claim form is correct. I understand that while I am in receipt of benefits I am obliged to immediately notify StateCover of **any change** in my condition or employment that affects my earnings or claim in any way, for example:

- i. Return to any work in any capacity;
- ii. Commence employment with another person / organisation;
- iii. Commence self employment / own business;
- iv. Cease treatment or change doctors.

I understand that it is an offence to fail to do so. In addition, I understand that I am obliged to participate and cooperate in the development and implementation of an Injury Management Plan to assist with my return to productive employment, in accordance with medical recommendations, where such a plan is instigated by StateCover or Council. I understand that any failure to do so may affect my entitlement to workers compensation benefits.

I hereby authorise the collection and exchange of written and verbal personal information between my medical / treatment practitioners, my employer, StateCover Mutual Limited and the WorkCover Authority as provided by the NSW workers compensation legislation, with respect to the injury / disease described in this claim form.

I agree that a copy of this Declaration shall have the same effect and authority as the original. I understand that, if any information I have given in this claim form is untrue, my claim may be denied and I may be prosecuted.

Signature of Claimant: Date:

TO BE COMPLETED BY COUNCIL

Date Claim received:
Signature of Council representative:.....Date:.....