Claim Form for Dependents of Deceased Workers

Workers Rehabilitation and Compensation Act 1988

PLEASE READ INSTRUCTIONS CAREFULLY

✓ If you are unable to fill in the form, please arrange for it to be completed on your behalf.
✓ If you require access to an interpreter, please contact the Translating and Interpreting Service on 131 450.
✓ If you require assistance to complete this form please telephone the WorkCover Tasmania Helpline on 1300 366 322 (cost of local call) OR (03) 6166 4600 (outside Tasmania).
✓ When completed, send this form to the deceased worker's employer within 6 months of the death of the worker. However, it is best to lodge this form as soon as possible.

✓ Use a ballpoint pen when completing this form and print all answers clearly.
✓ Ensure the form is complete and legible.
✓ The information provided on this form is important for the management of the claim. All sections must be completed by all parties concerned. If there is insufficient space for answering any questions on this form please attach additional notes.
✓ Personal information collected from you for workers compensation processes will be used by the WorkCover Tasmania Board for that purpose and may be used for other purposes permitted by the *Workers Rehabilitation and Compensation Act 1988* and associated laws.
✓ Failure to provide this information may result in your claim not being processed or records not being properly maintained. Your personal information may be disclosed to contractors and agents of the organisations authorised to collect it.
✓ The information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by you on request to the WorkCover Tasmania Board. You may be charged a fee for this service.

ENTITLEMENT

- Where a worker dies from a work-related injury or disease, their dependents may be entitled to compensation. This may include:
  - weekly payments
  - lump sum payment
  - compensation for the worker's medical expenses
  - compensation for counselling costs
  - compensation for burial or cremation costs
- Please note that where there are no dependents, the next of kin or family may claim for compensation in the case of burial or cremation costs as well as reasonable counselling costs.

TO THE CLAIMANT

- **Questions 1 to 61** must be completed by the claimant or by someone on behalf of the claimant.
- Dependents are members of the deceased workers family who:
  - were wholly or partially dependent upon the earnings of the worker at the time of the worker's death, or
  - would have been wholly or partially dependent on the earnings of the worker had the worker not been incapacitated by a work-related injury or disease.
- This includes the worker's spouse or caring partner. A spouse includes the person with whom a person is, or was at the time of his or her death in a significant relationship, within the meaning of the *Relationships Act 2003.* A caring partner is a person who was in a caring relationship with the worker which was the subject of a deed of relationship registered under the *Relationships Act 2003.*
- A dependent child is a person who is:
  - under the age of 16 years, or
  - 16 years of age or more, but less than 21 years of age and is a full time student and who is partially or totally dependent on the worker.
- Give the completed form and any accounts to the employer of the deceased worker as soon as possible.
- Make sure you **keep a copy** of this form.

TO THE EMPLOYER

- **Notify your insurer of the claim** either by phone, fax or email **within three working days from receipt of this form**. Failure to provide notice of the claim will preclude you from indemnity for weekly payments for the period that notice was not given to your insurer (see Section 36 of the Act).
- Complete the Employer's Details section of this form **(questions 62 to 84)**.
- Calculate the number of FTEs (full time equivalent). The FTE of a full-time worker is equal to 1.0. The calculation of the number of FTE for a part-time or casual worker is based on the proportion of hours worked divided by the number of full-time hours, resulting in a number in the range of 0 to 1.
- Calculate the **normal weekly earnings (NWE)**. NWE are the average earnings over the 12 months prior to the date of death. Where the deceased was continuously employed by the same employer for less than 12 months, the NWE is calculated as the average earnings for the period employed prior to the date of death. Where the deceased was employed by the employer for 14 days or less prior to the date of death, refer to Section 69(2) of the Act.
- Calculate the **normal weekly hours (NWH)**. NWH are the average number of hours per week for which the deceased worker was employed by the employer. Where the deceased worker was employed by the employer for 14 days or less prior to the date of death refer to Section 69B(2C) of the Act.
- Overtime/excess hours are not to be included in NWE or NWH unless all of the following criteria are met:
  (a) overtime/excess hours were a condition of the deceased worker's contract of employment;
  (b) overtime/excess hours were worked in accordance with a roster;
  (c) the pattern was substantially uniform; and
  (d) the deceased worker would have continued to work the overtime/excess hours if he/she had not been fatally injured. (see Sections 69(2D) and 70(2)(ab) of the Act).
- Calculate the **ordinary time rate of pay per week**. This relates to the payment for the deceased worker for the work in which, and the hours during which, he/she was engaged immediately before the date of death. (see Section 69 of the Act).
- Send this form and accounts to **your insurer within 5 working days of receipt from worker**.
- Make sure you **keep a copy** of this form.

On completion:

Claimant – keep a copy of form and send original with any accounts to the deceased worker's Employer

Employer – keep a copy of form and send original with any accounts to your Insurer

Insurer – keep original and send a copy of form to WorkCover Tasmania

Information and Assistance

For information and assistance on all workers compensation matters,
telephone: 1300 366 322 (cost of local call) OR (03) 6166 4600 (outside Tasmania)

Claimant's Details

1 Title (Mr/Mrs/Miss/Ms)

2 Surname

3 Given names

4 Residential address

Postcode:

5 Postal address *(if different from residential)*

Postcode:

6 Daytime contact phone numbers

M W H

7 Relationship to deceased
i.e. executor, wife/defacto, son, daughter

8 E-mail address

9 Date of birth ..../........../.............

10 Gender Male ☐ Female ☐

11 Country of birth Australia ☐ Overseas ☐

If overseas print country of birth *Office Use*

12 If you have difficulty understanding English, what is your preferred language? *Office Use*

Dependant/s Details

Please provide full details of all known dependants (including children not yet born) who are claiming entitlement. If space is insufficient please attach details.

Where the claimant is also a dependant please provide full details.

For more information see front page for definition of dependant.

Payment of child pensions are required to be made to their guardian for their benefit. Please provide details of the guardian for each child under 18 years of age.

Spouse/caring partner

13 Full name of spouse/caring partner

14 Address of spouse/caring partner

Postcode:

15 Date of birth ..../........../.............

16 Relationship to deceased

17 Dependency Wholly ☐ Partly Dependent ☐

18 Daytime contact phone numbers

M W H

Dependant child one

19 Full name of dependent

20 Address of dependent

Postcode:

21 Date of birth ..../........../.............

22 Relationship to deceased

23 Dependency Wholly ☐ Partly Dependent ☐

24 Full name of guardian (if applicable)

25 Address of guardian

Postcode:

26 Daytime contact phone numbers Dependent ☐ Guardian ☐

M W H

Dependant child two

27 Full name of dependent

28 Address of dependent

Postcode:

29 Date of birth ..../........../.............

30 Relationship to deceased

31 Dependency Wholly ☐ Partly Dependent ☐

32 Full name of guardian (if applicable)

33 Address of guardian

Postcode:

34 Daytime contact phone numbers Dependent ☐ Guardian ☐

M W H

Dependant child three

35 Full name of dependent

36 Address of dependent

Postcode:

37 Date of birth ..../........../.............

38 Relationship to deceased

39 Dependency Wholly ☐ Partly Dependent ☐

40 Full name of guardian (if applicable)

41 Address of guardian

Postcode:

42 Daytime contact phone numbers Dependent ☐ Guardian ☐

M W H

Deceased Worker's Details

43 Title (Mr/Mrs/Miss/Ms)

44 Surname

45 Given names

46 Residential address

Postcode:

47 Date of birth ..../........../..............

48 Gender Male ☐ Female ☐

49 Country of birth Australia ☐ Overseas ☐

If overseas print country of birth

Office Use

Details of Fatal Injury/Disease

50 Date and time of fatal injury ..../........../.............. : am/pm

51 In the case of a disease

(i) What was the date of diagnosis ..../........../..............

(ii) When was the deceased first incapacitated by the disease? ..../........../..............

(iii) Date of death ..../........../..............

Describe how the fatal injury or disease occurred

(i) Please provide the details of what happened, how it happened and what was involved (Please attach a separate page if necessary)

(ii) What was the cause of death?

Office Use

Mech	*Agency of Injury*	*B/down Agency of Injury*	*Injury*	*POB*

52 Address where the fatal injury or disease occurred

Postcode:

53 Where did the fatal injury or disease occur?

At work – at normal workplace ☐

At work—road traffic accident ☐

At work—on break ☐

Commuting/journey ☐

Away from work during recess period ☐

At work – working away from normal workplace ☐

Other ☐

If police attended the incident please provide if known:

54 Name of officer

55 Name of police station or branch

56 Was the deceased employed in any other job (other than the one in which they were injured) at the time the fatal injury or disease occurred? No ☐ Yes ☐

If Yes go to 56 (i), if No go to 57

(i) Second employer's legal name

(ii) Second employer's trading name or State Government Department

(iii) Second employer's address

Postcode:

(iv) Australian Business Number (ABN)

(v) Employment status

Full-time ☐ Part-time ☐ Casual ☐

(vi) Average weekly hours worked with second employer

(vii) Date deceased started work with second employer

(viii)Average gross weekly earning

Authority to Release Medical Information

Note: You do not have to complete this Authority. However, not doing so may mean delays to your claim being finalised.

I hereby authorise any medical practitioner or any other person or Registrar of any hospital who treated the deceased to disclose to the deceased worker's employer or his/her insurer any information regarding the deceased worker's medical history. A photocopy of this authority is to be considered as valid as the original.

57 Your signature

58 Date signed ..../........../..............

Claimant's Statement

In completing this claim for compensation I acknowledge that I have read the details provided on the first page of this form. I acknowledge that it is an offence under the Workers Rehabilitation and Compensation Act 1988 *to make a statement that is false or misleading.*

I hereby authorise any doctor, health authority, allied health provider, rehabilitation provider or other insurer to disclose to the workers compensation licensed insurer and WorkCover Tasmania any information regarding the deceased worker's medical history relevant to this claim. I agree to advise the employer if I become aware of any matter that would make the above information false or misleading.

I understand WorkCover may be required or authorised by law to release information or documents to other parties.
The information I have provided is true and not misleading.

59 Your signature

60 Date signed ..../........../..............

61 Date claim form given to employer ..../........../..............

Employer's Details

62 Employer's legal name, i.e. Registered Company Name, State Government Department, Partnership, Sole Trader's Name

e.g. J Citizen Pty Ltd, Department of Education

63 Australian Business Number (ABN)

64 Employer's address

Postcode:

65 Daytime contact phone numbers

M W H

66 Employer's trading name or State Government Department

67 Industry of employer

e.g. dry-cleaning services, dental services

Deceased Worker's Employment

68 Normal weekly earnings $

(see front page for explanation)

69 Ordinary time rate of pay per week $

(see front page for explanation)

70 Normal weekly hours (hrs).......... (mins)..........

(see front page for explanation)

71 Average days usually worked per week

72 Occupation of deceased at time fatal injury or disease occurred *Office Use*

73 Date the deceased started in your employment ..../........../..............

74 Was the deceased a:

- Direct employee ☐
- Working director ☐
- Contractor ☐
- Worker of contractor ☐
- Sub contractor ☐
- Labour hire worker ☐
- Apprentice/trainee ☐
- Other ☐

If 'other' give details below e.g. in training program, police volunteer, fire fighting/fire prevention operations

75 Was the deceased a:

- Permanent employee ☐
- Casual employee ☐
- Temporary employee ☐
- Temporary overseas visa worker ☐

76 If applicable, was the deceased: Full-time ☐ Part-time ☐

Office Use

Employer Contact Information

Please give the name of someone who can be contacted for further information about this claim

77 Contact name

78 Position

79 Contact phone

Employer Certification

The Workers Rehabilitation and Compensation law imposes heavy penalties for giving false or misleading information.

I am satisfied that the information given on this form is true and correct ☐

I believe that further investigation into this claim is required ☐

80 Employer representative's signature

81 Date signed ..../........../..............

82 Name of representative

83 Position

84 Date claim form lodged with insurer ..../........../..............

Insurer's Details

85 Insurer name *Office Use*

86 Policy number

87 ANZSIC classification of policy

88 Claim number

89 Date claim received by insurer *(for self-insurers this date will be the same as shown in question 84)* ..../........../..............

Preliminary Assessment of Entitlements

90 Have section 67A weekly payments been commenced to the wholly or partially dependent spouse, caring partner or child (on a without prejudice basis where applicable)?

Yes ☐ No ☐ Not applicable ☐

91 Please provide an indication of the entilements to be paid:

- ☐ compensation for the deceased's medical expenses
- ☐ compensation for counselling costs
- ☐ compensation for burial or cremation costs
- ☐ lump sum payment
- ☐ liability determination pending