SAVE AS PRINT

NSW GOVERNMENT | WorkCover

Uninsured liabilities

Worker claim form

1. YOUR PARTICULARS

(a) Surname

(b) Given names

(c) Date of birth DD/MM/YYYY

(d) Sex ☐ Male ☐ Female

(e) Marital status

(f) Language spoken at home

(g) Country of birth

(h) Do you need an interpreter ☐ Yes ☐ No

(i) Residential address

(j) Postcode

(k) Tax file number

(l) Medicare number

(m) Telephone number

(n) Mobile number

Please complete section 2 and/or 3, depending on whether you have received an injury and/or condition.

2. PARTICULARS OF YOUR INJURY

(a) Date of injury DD/MM/YYYY

(b) Time of injury HH:MM am/pm

(c) Date you stopped work DD/MM/YYYY

(d) What was your injury?

(e) Give a brief description of how your injury occurred, and what you were doing at the time

(f) What part of your body was injured?

(g) Was this part of your body normal before the accident?

(h) Were there any witnesses? ☐ Yes ☐ No If YES, give name (please obtain statement on form provided)

WORK SAFE HOME SAFE

3. PARTICULARS OF YOUR CONDITION

(a) Date you became aware of your condition DD/MM/YYYY

(b) Date you stopped work DD/MM/YYYY

(c) Approximate time you became aware of your condition HH:MM am/pm

(d) What is your condition?

(e) Give a brief description of how the condition occurred, and what you were doing at the time

(f) What part of your body does it affect?

(g) Was this part of your body normal before the condition?

(h) Were there any witnesses? ☐ Yes ☐ No If so, give name (please obtain statement on form provided)

4. OTHER INJURIES OR CONDITIONS

(a) Have you previously suffered from a similar injury or condition? ☐ Yes ☐ No

(b) Date of previous injury DD/MM/YYYY

(c) Did it happen at work? ☐ Yes ☐ No If YES, give name of employer

(d) How did the injury occur?

(e) What was the injury?

(f) How long were you off work?

(g) Claim number

(h) Name of insurance company

(i) Was your claim paid? ☐ Yes ☐ No

5. WHAT ARE YOU CLAIMING?

(a) Are you claiming weekly compensation payments? ☐ Yes ☐ No

(b) Period claimed (c) No capacity for work from DD/MM/YYYY to DD/MM/YYYY

(d) Has capacity for work from DD/MM/YYYY to DD/MM/YYYY

(e) Are you claiming medical expenses? ☐ Yes ☐ No

(f) Have you received payment from your employer or any other source in relation to this injury? ☐ Yes ☐ No

If YES, give details (ie Wages, Refund of Medical Costs etc) and attach a list of items and accounts that have already been paid (if you have original receipts or copies of accounts please send these)

(g) Are you receiving or in the process of receiving payments from Centrelink? ☐ Yes ☐ No

If YES, what is your Centrelink number

What type of allowance

(h) Are you participating in a rehabilitation program? ☐ Yes ☐ No If YES, with whom

6. DETAILS OF YOUR EARNINGS

(a) What was your gross (before tax is taken out) weekly wage at the time of the injury?

(b) How many hours did you work per week?

(c) What was your Award Classification? (if known, eg carpenter, boilermaker)

(d) What was your Award rate of pay? (if known)

(e) Have you given your employer the Report of Injury form to complete? ☐ Yes ☐ No

7. DETAILS OF YOUR EMPLOYER AND YOUR EMPLOYMENT AT THE TIME OF YOUR INJURY/ CONDITION

(a) Name of employer

(b) Date commenced with employer DD/MM/YYYY

(c) Termination date DD/MM/YYYY

(d) Type of business of your employer (eg restaurant/building etc)

(e) Registered office or business address of your employer

(f) Where did your employer's business operate from?

(g) Address where you were working at the time of the injury

(h) Who did you report your injury to?

(i) Is your employer still conducting this business or trade? ☐ Yes ☐ No

If NO, do you know what your employer's current address and phone number is?

(j) Who can we contact at your employer's business?

(k) Telephone number

(l) Did you work only for this employer? ☐ Yes ☐ No

If NO, give details of other employment

(m) Were you carrying on a trade or business on your own account or in partnership with others? ☐ Yes ☐ No

If YES, describe the trade or business and business name

(n) Did you employ anyone in carrying out your trade or business? ☐ Yes ☐ No (o) Did you sublet? ☐ Yes ☐ No

8. CONTRACT WORK

(a) Was your employer a sub-contractor? ☐ Yes ☐ No ☐ Don't know

If YES, give name of contractor

(b) Were you working at the contractor's premises when you suffered the injury? ☐ Yes ☐ No

9. OTHER CURRENT EMPLOYERS

Are you working now? ☐ Yes ☐ No

If YES, name and address of employer

Telephone number

Type of employment

Number of hours worked

Wages

If NO, are you looking for work? ☐ Yes ☐ No

Please give the name of the doctor(s) or hospital(s) where you received treatment for this injury or condition.

Name

Telephone number

Address

Postcode

Name

Telephone number

Address

Postcode

DECLARATION

I, _____ hereby solemnly and sincerely declare that the foregoing particulars are correct in every detail, and I have not withheld any information and that the injuries I have received were caused in the manner stated above and in no other way whatsoever, AND make this solemn declaration by virtue of the provisions of the *Oaths Act 1900*.

I understand that while I am in receipt of weekly payments of compensation, I am obliged to forthwith notify WorkCover NSW of (a) my commencing employment with some other person, or (b) my commencing my own business, or (c) any change in my circumstances. I am aware that it is an offence not to do so.

Declared at (place) _____ on Date DD/MM/YYYY

Signature of injured worker

_____

in the presence of an authorised witness, who states:

I, _____, a _____

(name of authorised witness) (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply)

1. *I saw the face of the person OR *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering.
2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I have confirmed the person's identity using an identification document and the document I relied on was:

   _____ (describe identification document relied on)

Signature of authorised witness

_____

Date DD/MM/YYYY

INTERPRETER'S DECLARATION

I, _____ of _____, an interpreter fluent in the _____ language, hereby solemnly and sincerely declare that I have translated faithfully and accurately the questions contained herein to the injured worker whose signature appears above, have accurately translated the answers given by the said injured worker, such answers faithfully entered herein. I make this solemn declaration in the knowledge that if such is untrue that I will be liable to prosecution under the *Oaths Act 1900*.

Signature

_____

Date DD/MM/YYYY

Name

_____

Address _____ Postcode _____

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

Uninsured liabilities

Checklist

Have you enclosed the following:

- Claim form completed ☐
- Claim form signed ☐
- Employers Report of Injury ☐
- Statement of Witness ☐
- PIAWE form ☐
- Group certificates, pay slips etc ☐
- Medical report (if available) ☐
- Medical authority ☐
- Original medical accounts/receipts ☐
- WorkCover certificate of capacity ☐
- Employment Declaration form **(Section B not to be completed)** ☐
- Statutory Declaration ☐

HEARING LOSS ONLY

- Notice of Injury form ☐

MOTOR VEHICLE ACCIDENT AND JOURNEY CLAIMS ONLY

- Motor Vehicle Accident/Other Work Related Injuries – Claim Form ☐
- Police Report (if available) ☐

You are now ready to send your claim to:

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

Uninsured liabilities

Medical authority

I,

Of

Hereby authorise WorkCover NSW to obtain any medical/clinical reports and notes in respect of the following injury/condition

Suffered by me on the

Whilst in the employ of

I further agree that a Certified Copy of this Authority will be accepted as verification of the original document.

Signature

Date

DD/MM/YYYY

NSW GOVERNMENT | WorkCover

Uninsured liabilities

Employer's report of injury

To be completed by the immediate employer of the injured worker and returned to WorkCover NSW, Locked Bag 2906, Lisarow, NSW 2252, within seven days of receipt.

EMPLOYER DETAILS

Full trading name

Location address (specify number, street, suburb) | Postcode

Facsimile number | Telephone number

Workers Compensation Insurer | Policy number

Covering from DD/MM/YYYY to DD/MM/YYYY

Registered office or business address | Postcode

Name and location where worker was employed (depot, branch, site)

Number of employees at site | Business activity or profession

CONTRACT WORK

Were you trading as a Sub-Contractor? ☐ Yes ☐ No

If YES, give name of Principal Contractor

Registered office or business address of Principal Contractor | Postcode

Nature of Principal Contractor's business

Did the Principal Contractor have Workers' Compensation Insurance at the time of the injury? ☐ Yes ☐ No

If YES, give insurance company | Policy number

WORK SAFE HOME SAFE

INJURED WORKER'S EMPLOYMENT PARTICULARS

Surname

Given names

Date employed
DD/MM/YYYY

Date employment ceased
DD/MM/YYYY

Was the worker your employee? ☐ Yes ☐ No If YES, please complete the following:

Full time or Part time (F/P)

Employed as Permanent or Casual (P/C)

Hours worked per week

Occupation

Main tasks performed by worker

Gross weekly wage paid

Award classification

Award rate of pay

If NO, explain the nature of the employment relationship

INJURY DETAILS

Where did the injury occur?

During a break at work? ☐ Yes ☐ No At work? ☐ Yes ☐ No Away from work during a recess? ☐ Yes ☐ No

Vehicle accident? ☐ Yes ☐ No While working? ☐ Yes ☐ No Travelling to or from place of employ? ☐ Yes ☐ No

Date of injury
DD/MM/YYYY

Time of injury
HH:MM am/pm

Date notice given
DD/MM/YYYY

Time notice given
HH:MM am/pm

To whom was the accident reported?

Address and place where injury occurred

Postcode

Telephone number

Details of previous related injuries (if known)

How did the injury occur and what was the worker doing at the time? (eg slipped while walking down stairs)

Describe the worker's injury or condition (eg laceration, dermatitis)

Which parts of the body were affected? (eg upper arm, ankle)

GIVE DETAILS OF OTHER CIRCUMSTANCES WHICH WOULD ASSIST WORKCOVER TO ASSESS THE CLAIM

Do you believe this is a genuine claim? ☐ Yes ☐ No If NO, why?

TIME LOST AS A RESULT OF INJURY

Date worker ceased work
DD/MM/YYYY

Time
HH:MM am/pm

Has worker resumed work?
☐ Yes ☐ No

If YES, date resumed work
DD/MM/YYYY

to
DD/MM/YYYY

Amount
$0.00

Medicals (Amount)

Other (please specify)

REHABILITATION

Have you provided rehabilitation? ☐ Yes ☐ No If NO, are you willing to provide rehabilitation? (eg light duties) ☐ Yes ☐ No

DECLARATION

I, _____ hereby solemnly and sincerely declare that the foregoing particulars are correct in every detail, and I have not withheld any information, AND make this solemn declaration by virtue of the provisions of the *Oaths Act 1900*.

Declared at (place) _____ on Date DD/MM/YYYY

Signature of employer

in the presence of an authorised witness, who states:

I, _____ (name of authorised witness), a _____ (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply)

1. *I saw the face of the person OR *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering.
2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I have confirmed the person's identity using an identification document and the document I relied on was: _____ (describe identification document relied on)

Signature of authorised witness

Date DD/MM/YYYY

INTERPRETER'S DECLARATION

I, _____ of _____, an interpreter fluent in the _____ language, hereby solemnly and sincerely declare that I have translated faithfully and accurately the questions contained herein to the injured worker whose signature appears above, have accurately translated the answers given by the said injured worker, such answers faithfully entered herein. I make this solemn declaration in the knowledge that if such is untrue that I will be liable to prosecution under the *Oaths Act 1900*.

Signature

Date DD/MM/YYYY

Name

Address

Postcode

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

Uninsured liabilities

Industrial deafness – Notice of injury form

Note: Claims for industrial deafness must be made against the last employer who employed you in an employment to the nature of which the injury was due.

If you need help in filling out this form please contact WorkCover NSW on 13 10 50.

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

PERSONAL DETAILS

Surname

Given names

Date of birth
DD/MM/YYYY

Sex
☐ Male ☐ Female

Marital status

Occupation

Language spoken at home

Country of birth

Do you need an interpreter
☐ Yes ☐ No

Residential address

Postcode

Telephone number

EMPLOYER DETAILS

Please name the employer who you are claiming against

ABN

Address

Postcode

What was the date of the last day you worked for the employer you are claiming against?
DD/MM/YYYY

Have you received any previous award/settlement in respect of industrial deafness? ☐ Yes ☐ No

If YES, please provide details

EMPLOYER DETAILS (continued)

Employment details for five years prior to the date you stopped working for the nominated noisy employer

Industry in which employed	Employer's name and address	Occupation	Period of employment

List details of your employment since you stopped working for the nominated noisy employer to present.

Industry in which employed	Employer's name and address	Occupation	Period of employment

DECLARATION

I, _____ hereby solemnly and sincerely declare that the foregoing particulars are correct in every detail, and I have not withheld any information and that the injuries I have received were caused in the manner stated above and in no other way whatsoever, AND make this solemn declaration by virtue of the provisions of the *Oaths Act 1900*.

Declared at (place) _____ on Date DD/MM/YYYY

Signature of injured worker

in the presence of an authorised witness, who states:

I, _____, a _____

(name of authorised witness) (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply)

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_____ (describe identification document relied on)

Signature of authorised witness

Date DD/MM/YYYY

INTERPRETER'S DECLARATION

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Signature

Date

DD/MM/YYYY

Name

Address

Postcode

NSW GOVERNMENT | WorkCover

Uninsured liabilities

Other Work Related Injuries – Claim Form

1. You should complete this form only if you were injured while travelling from home to work or travelling from work to your home.
2. If this injury involves a motor vehicle you must also please complete a Motor Vehicle Accident Form.

JOURNEY ACCIDENTS

(a) Were you travelling from home to work? ☐ Yes ☐ No (b) Were you travelling from work to home? ☐ Yes ☐ No

(c) Were you travelling TO or FROM a trade or technical school? ☐ Yes ☐ No

(d) Were you following your usual route? ☐ Yes ☐ No

If NO, please provide details

(e) What type of transport were you using?

(f) What time did you commence the journey? HH:MM am/pm

(g) Where did the accident happen?

(h) Was your journey broken for any reason? ☐ Yes ☐ No

If YES, please given details

(i) Had you consumed alcohol or drugs? ☐ Yes ☐ No

If YES, please describe what you had consumed and how much?

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DECLARATION

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Declared at (place) _____ on Date DD/MM/YYYY

Signature of injured worker

_____

in the presence of an authorised witness, who states:

I, _____ (name of authorised witness), a _____ (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply).

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2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I have confirmed the person's identity using an identification document and the document I relied on was:

   _____ (describe identification document relied on)

Signature of authorised witness

_____

Date DD/MM/YYYY

Uninsured liabilities

Motor vehicle accident claim form

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

DRIVER/PASSENGER/MOTOR CYCLE/BICYCLE ACCIDENT DETAILS

(a) Were you at the time of injury the driver? ☐ Yes ☐ No

(b) Were you at the time of injury the passenger? ☐ Yes ☐ No

If you were a passenger, please list the name and address of driver of the vehicle you were travelling in:

Name and address of vehicle driver

Name and address of vehicle owner

Registration number and make of vehicle

Name of Third Party Insurance Company

(c) Details of other vehicle(s) involved in the accident (if more than one vehicle, give details of all)

Name and address of driver

Name and address of vehicle owner

Registration number and make of vehicle

Name of Third Party Insurance Company

(d) Names and addresses of any witnesses

(e) Police Station to which the accident was reported

(f) Did police attend scene? ☐ Yes ☐ No Police officer's name

(g) Police action taken or proposed

(h) Who in your opinion was responsible for the accident?

(i) If you were a passenger, had the driver consumed alcohol or drugs prior to the accident? (please tick)

☐ Yes ☐ No ☐ Don't know

If YES, how much?

DRIVER/PASSENGER/MOTOR CYCLE/BICYCLE ACCIDENT DETAILS (continued)

(j) If you were a driver or passenger, were you wearing a seat belt? ☐ Yes ☐ No

If NO, why?

(k) If you were a rider or passenger on a motor cycle or bicycle, were you wearing a helmet? ☐ Yes ☐ No

If NO, why?

(l) Have you lodged a Third Party Insurance Claim? ☐ Yes ☐ No

If YES, name of insurer

Claim number

PEDESTRIAN ACCIDENT DETAILS

(a) Details of all vehicles involved in the accident in which you were a pedestrian

Name and address of driver

Registration number and make of vehicle

Name of Third Party Insurance Company

(b) Names and addresses of any witnesses

(c) Police Station to which the accident was reported

(d) Did police attend scene? ☐ Yes ☐ No Police officer's name

(e) Police action taken or proposed

(f) Who in your opinion was responsible for the accident?

(g) Have you lodged a Third Party Insurance Claim? ☐ Yes ☐ No

If YES, name of insurer

Claim number

Please make a rough plan of the road showing the position of all vehicles and persons concerned at the time of the accident, name of the road(s), and show by an arrow the direction in which they were travelling when the accident occurred. Please clearly mark the identity of each vehicle or person.

DECLARATION

I, _____ hereby solemnly and sincerely declare that the foregoing particulars are correct in every detail, and I have not withheld any information and that the injuries I have received were caused in the manner stated above and in no other way whatsoever, AND make this solemn declaration by virtue of the provisions of the *Oaths Act 1900*.

Declared at (place) _____ on Date DD/MM/YYYY

Signature of injured worker

_____

in the presence of an authorised witness, who states:

I, _____ (name of authorised witness), a _____ (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply)

1. *I saw the face of the person OR *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering.
2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I have confirmed the person's identity using an identification document and the document I relied on was:

   _____ (describe identification document relied on)

Signature of authorised witness

_____

Date DD/MM/YYYY

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Uninsured liabilities

Statement of witness

Name of injured person

Who was the injured person working for at the time of the accident?

Name of supervisor or other person in authority in charge of the injured person

Where did the accident happen?

Date of injury DD/MM/YYYY Time HH:MM am/pm

OR

The date when you became aware of the condition DD/MM/YYYY Time HH:MM am/pm

How did the injury/condition happen?

Describe, as far as practicable, the injuries sustained (eg laceration, broken leg)

Did you actually see the accident? ☐ Yes ☐ No If YES, how near were you to the injured person? (Metres/Feet)

Were there any other people who witnessed the injury? ☐ Yes ☐ No

If YES, please give contact details

Describe anything which you partially noticed about the injured person after the accident (such as bleeding, vomiting, limping) and also whether and for how long the person continued working in a normal manner.

DECLARATION

I, _____ hereby solemnly and sincerely declare that the foregoing particulars are correct in every detail, and I have not withheld any information and that the injuries I have received were caused in the manner stated above and in no other way whatsoever, AND make this solemn declaration by virtue of the provisions of the *Oaths Act 1900*.

Signature of witness

Date DD/MM/YYYY

Address of witness

Postcode

Name of witness

Declared at (place)

on Date DD/MM/YYYY

in the presence of an authorised witness, who states:

I, _____, a _____

(name of authorised witness) (qualification of authorised witness ie Justice of the Peace/Solicitor)

certify the following matters concerning the making of this *statutory declaration/affidavit by the person who made it: (*please cross out any text that does not apply)

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2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I have confirmed the person's identity using an identification document and the document I relied on was:

_____ (describe identification document relied on)

Signature of authorised witness

Date DD/MM/YYYY

If you have any questions please contact WorkCover NSW on 13 10 50.

WorkCover NSW, Claims Branch, Locked Bag 2906, Lisarow, NSW 2252.

Calculating pre-injury average weekly earnings

If an injured worker is unable to perform his or her pre-injury job, or suitable alternative duties, as a result of a work-related injury or illness, any weekly compensation that might be payable is calculated by reference to the worker's pre-injury average weekly earnings (PIAWE).

The PIAWE is the average of weekly earnings over the 52 week period prior to the injury (subject to some exceptions noted below).

The calculation of earnings must take into account any periods of paid leave, but must not include any periods of unpaid leave.

The main component of PIAWE will be the worker's ordinary earnings, which are for each week:

- If the worker is paid on the basis of ordinary hours worked in a week, the sum of the amounts paid or payable for:
  - earnings for the hours the worker worked or was on paid leave in that week
  - overtime and shift allowances (but only for calculating compensation in the first 52 weeks of incapacity)
  - piece rates
  - commissions
  - the value of non-pecuniary benefits (eg residential accommodation, use of a motor vehicle, health insurance, or education fees)
  - any salary sacrifice arrangement.
- In any other case, the sum of the amounts paid or payable for:
  - the actual earnings of the worker (including paid leave in that week)
  - overtime and shift allowances (but only for calculating compensation in the first 52 weeks of incapacity)
  - piece rates
  - commissions
  - the value of non-pecuniary benefits (eg residential accommodation, use of a motor vehicle, health insurance, or education fees)
  - any salary sacrifice arrangement.

If a worker has been employed for at least four weeks but less than 52 weeks, the PIAWE is calculated over the actual period of continuous employment with the employer prior to injury, but not including periods when the worker did not work or was not on paid leave.

If a worker has been employed for less than four weeks, the PIAWE is calculated on the basis of the average ordinary earnings the worker could reasonably have expected to earn in that employment (if it were not for the injury) for the period of 52 weeks after the injury.

If immediately before the injury the worker was not a full time worker, but at the time of injury had been seeking full time employment and had been, in the previous 78 weeks, predominantly a full time worker, the PIAWE is calculated as the average ordinary earnings with all employers over that 78 week period, but not including periods when the worker did not work or was not on paid leave.

For workers who had been employed by two or more employers at the time of injury there are special ways of calculating the PIAWE and these are set out in a table in schedule 3 of the *Workers Compensation Act 1987* (WC Act).

Note: There are prescribed minimum and maximum rates of weekly compensation which are adjusted from time to time.

Claim number

PIAWE calculation form

This form has been developed to ensure that all relevant earnings information is provided to insurers where a worker has sustained an incapacity as a result of their employment and has an entitlement to weekly payments.

The information will assist the insurer to calculate the correct benefit payable in accordance with the provisions of the WC Act.

Injured workers can apply for an alteration of their weekly payments in accordance with section 42(1) of the WC Act, and will need to complete this form in support of their application.

Please forward this form to your insurer together with all documents supporting information provided on the form.

1. EMPLOYER DETAILS

Employer name

Policy number

2. WORKER DETAILS

Worker name

Date of birth (DD/MM/YYYY) / /

Employed since (MM/YYYY) /

Employment type: ☐ Full time ☐ Part time ☐ Casual ☐ Other

3. WAGE INFORMATION

Ordinary hours worked per week

Ordinary gross hourly rate $.

Ordinary gross earnings per week $.

Are any of the following paid on top of the ordinary gross earnings? Please provide the value of the payments for the 52 weeks prior to the date of injury.

Overtime $.

Shift allowances $.

Commission $.

Piece rates $.

Has there been any change in working hours/rates in the 52 weeks prior to the injury? This could include promotion, reduction in working hours etc. ☐ Yes ☐ No

Brief description of change

Date of change (DD/MM/YYYY) / /

4. LEAVE

In the 52 weeks prior to the date of injury was any leave taken? ☐ Yes ☐ No

Paid annual leave (weeks)

Paid other leave (weeks)

Unpaid leave (weeks)

5. NON-PECUNIARY BENEFITS

Were any of the following non-pecuniary benefits received as part of pay? Please state the monetary value of the non-pecuniary benefits, including the Fringe Benefits Tax value, in the 52 weeks prior to the date of injury.

Use of a motor vehicle
$.
Date commenced / /

Residential accommodation
$.
Date commenced / /

Health insurance
$.
Date commenced / /

Education fees
$.
Date commenced / /

Will the worker be retaining use of any of these non-pecuniary benefits while they are unable to work? If yes, please list each item.

6. SALARY SACRIFICE

Is any part of the weekly wage payment directed to another party (also known as salary sacrifice)? ☐ Yes ☐ No

If yes, please supply details:

Type

Amount

$

$

7. REASONS FOR REQUESTING AN ALTERATION OF WEEKLY PAYMENTS (to be completed by injured workers in support of applications in accordance with section 42(1) of the WC Act 1987)

Please state the reasons for the request for alteration of weekly payments.

8. OTHER EARNING DETAILS (to be completed by injured workers in support of applications in accordance with section 42(1) of the WC Act)

Do you have a second employer? If yes, please provide the following:

Employer name

Employer address

Unit number/Street number/Property number (include Lot or DP number if applicable)

Street name

Suburb

State

Postcode

Contact person

Employed since (DD/MM/YYYY)

/ /

9. DECLARATION

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

State name

Role (if not the injured worker)

Signature

Date (DD/MM/YYYY)

/ /

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