StateCover

Employee Claim Form

This form must be fully completed to properly make a claim for workers compensation in accordance with the Workplace Injury Management and Workers Compensation Act 1998.

To: ____ **Council**

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

CLAIMANT DETAILS

Title: ____ Given Name(s): ____ Surname: ____

Current Address: ____ State ____ Postcode ____

Mobile: ____ Telephone: ( ) ____ Facsimile: ( ) ____

Email Address: ____

Date of birth: ____ Gender: Male ☐ Female ☐

Country of birth: ____ Languages spoken: ____

Interpreter required: Yes ☐ No ☐

Date started in current position: ____

Full time ☐ Part time ☐ Casual ☐ Permanent ☐ Shifts ☐

Occupation/Position: ____

Daytime Contact or Mobile No. ____ **Usual Days and Hours of Work** ____

Supervisor's Name ____ **Supervisor's contact no.** ____

OTHER CURRENT EMPLOYERS (including self-employment)

Do you have any other employment Yes ☐ No ☐

If YES, please give details:

Full name of Employer: ____

Address: ____ State ____ Postcode ____

DEPENDENTS

Full name of dependent	Relationship to you	Date of birth	Full time student?	Residing at home?	Working?
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

WHAT HAPPENED?

How did the injury occur, and what were you doing at the time? (e.g. slipped while climbing a ladder)

Workplace name and address where injury occurred (e.g. works depot):

Address: State Postcode

Name and address of any person who was present when the incident/injury happened:

Title: Given Name(s) : Surname:

Address: State Postcode

INJURY DETAILS

When did the injury happen or when did you first notice the injury/disease?

Date of Injury: Time: am/pm Date notice given:

To whom was the injury reported?

If you stopped work due to injury/disease - Date and time stopped work:

Date: Time: am/pm

What injury(ies)/disease did you suffer (e.g. fracture)

What parts of the body were affected? (e.g. right upper arm, lower back)

OTHER SIMILAR INJURIES

Have you previously suffered any similar injury or condition? Yes ☐ No ☐

If YES, please give details:

Date of previous injury/condition:

________ to ________

Was the injury/condition resolved? Yes ☐ No ☐

If NO, give details:

Name of employer (if applicable):

MEDICAL TREATMENT

Name of treating Doctor:

Address: State Postcode

Mobile: Telephone: ( ) Facsimile: ( )

Email Address:

Name of hospital (if applicable):

SIRA approved Medical Certificate attached Yes ☐ 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 processing your claim, StateCover may collect personal and health information about you in relation to your claim. Personal and health information is collected about you on this form and may also be collected during the processing, assessing and management of your claim.

It may be collected from your current, previous and future employers, government agencies, credit reporting agencies, health service providers and other persons who can provide information relevant to your claim.

Personal health information about you may also be collected by solicitors, private investigators, loss adjusters and other service providers acting on behalf of StateCover.

Personal health information is collected for the purposes of enabling StateCover to process, assess and manage your claim and to verify any information you may submit in support of your claim.

For the purposes of processing, assessing and managing your claim, StateCover may disclose personal health information about you to the following types of organisations:

- State Insurance Regulatory Authority
- Your employers
- Solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers
- The Workers Compensation Commission
- Approved Medical Specialists
- A court or tribunal in the course of proceedings under any of the Acts administered by SIRA
- Any other person, organisation, or government agency authorised by you, or required by law

You may request access to your personal and health information collected by StateCover by contacting our office directly. You may also request the correction of any errors in the personal or health information held by StateCover.

A copy of our Privacy Policy is available on the StateCover website at **www.statecover.com.au** or can be made available on request.

EMPLOYEE DECLARATION

I (print name and position):

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 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 co-operate 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 State Insurance Regulatory 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 authorised person completing this form:

Date:

TO BE COMPLETED BY COUNCIL

Date claim received:

Cost Centre:

Signature of Council representative:

Date: