



Australian Government

Seafarers Safety, Rehabilitation  
and Compensation Authority

# Claim for Workers' Compensation

*Seafarers Rehabilitation and Compensation Act 1992*

## Notes for claimants

In this document, all references to 'the employer' mean the employer against whom this claim is made.

Please complete this form if you want to claim workers' compensation under the *Seafarers Rehabilitation and Compensation Act 1992* (Seafarers Act). This form is approved by the Seafarers Safety, Rehabilitation and Compensation Authority (Seacare Authority) in accordance with subsections 63(2)(a) and (b) of the Seafarers Act.

Once you have completed and signed this form, you must lodge it as soon as possible with the employer. Keep the **yellow** copy for your records. The employer will use the information on this form to determine your claim. The employer will also send the **blue** copy to the Seacare Authority which records data from the information on the form.

**Note:** If you intend to make a claim for compensation against more than one employer in relation to the same injury or illness, you must provide a notice to each employer stating the name and address of the other employer.

If you consider that another employer or employers materially contributed to the injury or illness, you must provide the employer against whom this claim is being made with a notice stating the name and address of the other employer or employers.

## Information about claiming workers' compensation, rehabilitation and return to work

The Seacare Authority produces guidance material to assist claimants and employers understand their rights and obligations regarding workers' compensation and rehabilitation. Copies of information brochures and booklets are available from the employer, your union office, from your health and safety representative or union delegate. Information is also available from the Seacare Authority website at [www.seacare.gov.au](http://www.seacare.gov.au)

Separate forms for Claims for Permanent Impairment and Non Economic Loss and/or Related Aids (Seacare Form 04) and for claims for Compensation by Dependents of Deceased Employees (Seacare Form 05) are available from the employer, or from the Seacare Authority.

## Assistance to return to work

The Seafarers Act requires the employer to provide you with assistance to remain at, or return to, work as soon and as safely as possible after you are injured or suffer a work related illness.

## Privacy and personal information

Personal information on this form is collected to help the employer and/or the employer's workers' compensation insurer, determine your eligibility for workers' compensation and related payments. The authority to collect this information is provided by section 63 of the Seafarers Act.

Personal information collected about you on this form is provided to the employer and to the Seacare Authority which maintains a database of Seacare scheme workers' compensation statistics, and in some cases to the Seacare Authority as the manager of the Seafarers Safety Net Fund established under section 96 or section 100 of the Seafarers Act. The Seacare Authority is required to comply with the applicable principles as set out in the *Privacy Act 1988*.

Personal information collected about you on this form can also be provided in certain circumstances to the employer's workers' compensation insurance company, an approved (rehabilitation) program provider, courts and tribunals, the Seacare Authority and government agencies such as Centrelink, the Department of Employment and Workplace Relations, Comcare and the Australian Safety and Compensation Council. In other circumstances personal information on this form can be disclosed without your consent where authorised or required by law.

**This sheet MUST be inserted beneath each  
page set as you complete this form.**

## What you need to do

### Step 1

#### Fill in this form

Please use a **black or blue hard tip pen** to answer the questions in this form.

Answer all questions. Where you are required to make a choice, please tick the appropriate box.

If your answers do not fit in the space provided, please attach additional pages with the details.

When you have answered all of the relevant questions please read and **sign the Authorisation, declaration and acknowledgement** on page 4.

**Please note:** It is an offence to provide false or misleading information in relation to a claim for compensation under the Seafarers Act.

If this form is not completed in full and if all relevant medical certificates are not attached it may delay a determination of your claim.

### Step 2

#### Collect the documents you need to provide to the employer

You will need to provide an **original medical certificate(s)** from a legally qualified medical practitioner (for example a general practitioner or medical specialist) to prove you have a work-related injury or illness. The certificate must show:

- a precise medical diagnosis of your condition;
- the relationship between the injury or illness and your employment;
- the certified period of incapacity for work; and
- any restrictions or limitations required for your condition and likely duration of these restrictions (that is, alternative duties you are able to perform).

Use the checklist on page 4 of this form to make sure you have provided all the required information so the employer can assess your claim promptly.

### Step 3

#### Lodge this form

When you have completed and signed this form and collected all the documents you need to support the claim, keep the **yellow** (claimant) **copy for your records**.

Provide the **white and blue copies and the attachments** to the Master of the ship or the Master's representative, or the employer against whom you are making a compensation claim. The employer will forward the blue copy and relevant attachments to the Seacare Authority.

**If the employer has gone out of business or no longer operates**, you should lodge the white and blue copies and the attachments with the Seafarers Safety Net Fund. The Fund representative is the Seacare Authority, GPO Box 9905, Canberra ACT 2601.

**If you are no longer employed**, you must provide this form to the employer you worked for when you were injured or contracted your illness.

### Help?

#### Do you need help with this form?

If you need assistance to complete this form, your supervisor onboard may be able to help you. Otherwise, you should contact the employer, or the employer's representative in your home port, your health and safety representative or your union delegate.



# Claim for Workers' Compensation

## Employee Details

### 1 Your full name

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Family name

Given name(s)

### 2 Date of birth

 /  / 

### 3 Gender

Male ☐

Female ☐

### 4 Permanent home address

(please give street address and not a PO Box)

State

Postcode

### 5 Postal address (if same as home address write 'as above')

State

Postcode

### 6 Contact telephone number

Home

(  )

Work

(  )

Mobile

### 7 Email address

### 8 Payroll number or PIN (if known)

### 9 Name of home port

### 10 Occupation at the time of the injury or illness (rank/rating)

## Claim Details

### 11 What is the nature of this claim? (Tick all applicable boxes)

**Note:** This question does not limit your entitlement to make further claims in relation to the injury or illness.

Lost wages resulting from an incapacity for work ☐

Medical and related expenses ☐

Travel expenses attending medical examination/rehabilitation  
(only round trips of 50 km or more are reimbursable) ☐

Rehabilitation program ☐

Alterations, aids or appliances ☐

Household and attendant care services ☐

Compensation for property loss and/or damage ☐

Death\* ☐

Permanent Impairment\*\* ☐

\*If claiming for Death Benefits this form needs to accompany Seacare Form 05 (Claim for Compensation by Dependents of Deceased Employees).

\*\*If claiming for Permanent Impairment this form needs to accompany Seacare Form 4 (Claim for Permanent Impairment and Non-Economic Loss and/or Related Aids).

## Duty Status and Ship Details

### 12 Name of the ship you were employed on when the injury or illness happened

### 13 Type of vessel – For example: bulk carrier, passenger ship, offshore supply ship, dredge, FPSO facility

### 14 What was your duty status when the injury or illness happened? (Tick all applicable boxes)

On duty: ☐ on the ship

☐ on the ship and on an authorised break

☐ away from the ship

☐ away from the ship and on an authorised break

Off duty: ☐ on the ship

☐ away from the ship (during periods of ordinary recess)

While travelling to or from: ☐ a ship

☐ a training facility

While attending an approved course of study ☐

Other - please specify

**15 Did your injury or illness happen while travelling to or from your workplace, a training facility or other authorised location?**

No ☐ ►► Go to Question 20

Yes ☐

**16 Where were you travelling from:**

To

Via

**17 Did you travel a route other than the direct route?**

No ☐

Yes ☐ ►► Please attach a map of the route taken

**18 Was the journey interrupted?**

No ☐

Yes ☐ ►► Please attach a separate sheet stating the reason for, and the duration of, the interruptions

**19 Did the police attend?**

No ☐

Yes ☐ ► Please attach a copy of the Police Statement or provide the Police Event number or Police reference number

### **Injury or Illness Details**

**20 When were you injured or when did you first notice you were ill? Give approximate time if exact time is not known.**

Date

Time  am/pm

**21 Did you report the injury or illness to the employer?**

No ☐

Yes ☐ ► When did you report it?

Date

Time  am/pm

Who did you report it to?

Name

Position in company

**22 Did you stop work as a result of the injury or illness?**

No ☐

Yes ☐ ► When did you stop?

Date

Time  am/pm

**23 Were you signed off the ship as a result of the injury or illness?**

No ☐

Yes ☐ ► Date you were signed off

Port where you were signed off

**24 What is the nature of the injury or illness you are claiming for? For example: fracture, loss of sight, burn.**

**25 What part(s) of your body were injured?**

For example: left upper arm, right eye, lower back muscles.

**26 Where did the injury or illness happen?**

If on board a ship please state the specific location.

For example: engine room, accommodation, alleyway.

**27 What were you doing when the injury or illness happened?**

For example: loading stores, mooring vessel.

**28 What equipment, substance and/or actions directly contributed to your injury or illness?**

For example: grinder, mooring rope, acid, fell down stairs.

**29 Were there any witnesses to your injury?**

No ☐

Yes ☐ ► Name of witness 1

Contact telephone

Name of witness 2

Contact telephone

If there were more than two witnesses to your injury please attach details

**30 What is the postcode of the place where the injury or illness happened?**

If on board a ship please write 9999

[illegible]

**32 Have you ever suffered a similar injury or illness to the one you are claiming for?**

No ☐ ►► **Go to Question 38**

Yes ☐

**33 When did that injury happen or when did you notice you were ill?** Give approximate date if exact date is not known.

/	/
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No ☐

Yes ☐ ► Were you paid compensation?

No ☐

Yes ☐


**38 Are you claiming for the loss of, or damage to any property?**  
Property is defined as 'property used by an employee restricted to an artificial limb or other artificial substitute, surgical or similar aid or an appliance, for example glasses, false teeth'.

No ☐ **Go to the 'Authorisation, declaration and acknowledgement' on the next page**

Yes ☐

Please attach receipts or evidence of purchase or replacement of repaired property


[illegible]

## Authorisation, declaration and acknowledgement

Please read and sign this authorisation, declaration and acknowledgement.

Please note that all references to 'the employer' mean the employer against whom this claim is made.

### I authorise and consent to:

- any medical practitioner, hospital, laboratory, rehabilitation provider, or other health practitioner providing details of any consultation, treatment or report in connection with this injury or illness to my employer or any relevant former employer, upon production of this authority or photocopy thereof.
- any employer for whom I work while I am receiving compensation benefits in respect of this claim, providing details of my wages or remuneration to the employer.
- information being obtained from any relevant authority to establish my seagoing work history.

### I declare that:

- I elect to claim benefits under the *Seafarers Rehabilitation and Compensation Act 1992* and not under an industrial award or agreement.
- the information I have provided in this form is true and correct.
- I will advise my employer of any intention I have to leave Australia.
- I will not engage in employment that is not approved by my employer as part of a rehabilitation program while in receipt of compensation benefits under the *Seafarers Act*.
- I will advise my employer if I receive weekly payments or a lump sum from a Superannuation Fund or the Seafarers Retirement Fund, or from any other source with respect to this injury or illness.
- I am aware that where my injury has lasted, or is likely to last, 28 days or more and has resulted in an impairment or incapacity to work that I must:
  - (i) participate in an assessment of my capacity to undertake a rehabilitation program; and
  - (ii) subject to that assessment, participate in an agreed rehabilitation program.

### I acknowledge that:

- my employer's workers' compensation insurer may exercise the authorities and rights of my employer in relation to this claim, whether those authorities or rights are conferred on my employer by this claim form or by the *Seafarers Rehabilitation and Compensation Act 1992*.
- it is an offence to provide false information in relation to a claim for compensation under the *Seafarers Rehabilitation and Compensation Act 1992*.
- I must advise the employer if I claim or receive benefits under state workers' compensation legislation, or benefits from Centrelink, such as Sickness Allowance.

### Your signature



Date

## Checklist


Please use this Checklist as a guide to ensure that you have completed this form and attached all necessary attachments before it is given to the employer.

Check that you have answered all the questions you are required to answer and have signed the Authorisation, declaration and acknowledgement. ☐

### Medical information

 Have you attached an **original medical certificate(s) from a legally qualified medical practitioner**? ☐

### Additional details

 If your injury or illness happened **while travelling** to or from your workplace, a training facility or other authorised location and:

- you travelled a route other than the direct route (Question 17), have you attached a **map of the route taken**? ☐
- the journey was interrupted (Question 18), have you attached a **separate sheet stating the reason for, and the duration of, the interruptions**? ☐
- the police attended (Question 19), have you attached a **copy of the Police Statement** or provided the Police Event number or Police Reference number? ☐

If there were more than two witnesses to your injury (Question 29), have you attached **details of the other witness(es)**? ☐

If you are claiming for loss/damage to property (Question 38), have you attached **receipts or evidence of purchase or replacement of repaired property**? ☐

If you intend to make a claim for compensation against more than one employer in relation to the same injury or illness, have you provided a notice to each employer stating the name and address of the other employer? ☐

If you consider that another employer or employers materially contributed to the injury or illness, have you provided the employer against whom this claim is being made with a notice stating the name and address of the other employer or employers. ☐

## What to do now

**Keep the yellow (claimant) copy** of this form. You may also want to keep a copy of your attachments for your records.

**Lodge the white and blue copies and original attachments** to the **Master of the ship** or the Master's representative, **or the employer** against whom you are making this compensation claim.

**If the employer has gone out of business or no longer operates**, lodge the white and blue copies and attachments with the **Seafarers Safety Net Fund**. The address is listed at Step 3 at the front of this document.