

Workers' compensation claim form and instructions >

NOTE:

All pages of the claim form must be downloaded including the employer's report.

All pages of the claim form must be submitted to your employer including the employer's report.

Instruction sheet

The NT WorkSafe **Workers' Compensation Claim Form** is the only approved form for lodging a claim for workers' compensation in the Northern Territory. In the event of a work related injury or disease, an employer or worker may download this form, which should then be completed by both the injured worker and the employer. See instructions below.

Injured worker

- ☐ Complete the claim form by printing clearly and answering all relevant questions.
- ☐ Make sure you sign the **Declaration** and **Authorisation for Medical and Personal Information** on the claim form.
- ☐ If you are unable to fill in this claim form you can arrange for someone else to complete the claim form on your behalf.
- ☐ The more information you provide on the form the quicker the claim can be progressed.
- ☐ If you are claiming compensation for **loss of income** you **must** submit a **Northern Territory Workers' Compensation First Medical Certificate** with your claim form. You will need to get this from your doctor.
- ☐ If you are claiming compensation for **medical expenses only**, you need only to provide the relevant account/s or receipt/s with your claim form.
- ☐ When you complete your claim form, attach your Northern Territory Workers' Compensation First Medical Certificate (if applicable) and any other relevant documents (eg medical receipts/accounts).
- ☐ Keep a copy of your Workers' Compensation Claim Form and any documents you have attached, for your own future reference.
- ☐ Hand or post your claim form to your employer as soon as possible.
- ☐ If you are posting the claim form to your employer it is advisable to send it by registered mail.

Employer

- ☐ When you receive the completed claim form from the injured worker, you need to complete all sections of the **Employer's Report on Incident**.
- ☐ When you have received the claim form you must complete it and forward it within **3 working days** to your relevant insurer, together with the Northern Territory Workers' Compensation First Medical Certificate (if applicable) and any other attached documents (eg medical receipts/accounts).
- ☐ Retain a copy of the claim form and attached documents for your own future reference.
- ☐ If the injured or ill worker is unable to complete a claim form please arrange for a claim form to be completed on their behalf.
- ☐ If a worker has died due to a work related injury or disease, **do not** fill in this claim form, instead please contact NT WorkSafe on our toll free number 1800 019 115 (Australia wide).

WORKERS' COMPENSATION CLAIM FORM

and EMPLOYER'S REPORT *Work Health Act 1986*

To the Worker

HOW TO CLAIM

- The employer should be informed of a work-related injury or disease as soon as practicable. This can be done either verbally or in writing.
- You may see a doctor of your choice. If the claim is for lost time, ask your doctor for a Northern Territory workers' compensation medical certificate and attach both copies to the claim form. If this certificate is not attached, the claim is not valid. Where the claim is for medical expenses only, you need only to provide the account or receipt with the claim form.
- Fill in the first 2 pages of the workers' compensation claim form and submit it with all relevant documentation attached, to your employer. Retain a copy of this form for your records. Note: You have up to 6 months to lodge your claim on your employer, however it may be in your best interest to lodge it as soon as practicable.
- If you can't fill in this form yourself you may ask someone else to help you.
- Once you have given your claim to your employer, your employer must complete section titled '**Employer's Report on Incident**' and send it to their insurer.
- The insurer will make a decision on the claim within 10 working days of the employer receiving it and advise you (in writing) if your claim is accepted, rejected or deferred. For further information on the process see NT WorkSafe Information Bulletin 13.01.16. This can be found on NT WorkSafe website at www.worksafe.nt.gov.au.

Note: For further information see **(INFORMATION FOR THE INJURED WORKER)** section of this form.

To the Employer

- Make sure a separate form is filled in for each injured or ill worker.
- Ensure the worker completes this claim form. If the worker is unable to complete this form please arrange for the form to be completed on their behalf.
- **Send the original form to your insurance company immediately (there may be a penalty if there is a delay of more than 3 working days).**
- Make sure the copy of the worker's medical certificate is included (where applicable).
- Keep a copy for your records.
- If a worker has died, do not fill in this form, please contact NT WorkSafe.
- Send other medical certificates and accounts to your insurer as they become available.
- If the claim is accepted and it involves lost time, then you should commence weekly payments to the worker within three (3) working days of the claim being accepted.
- If the insurer defers liability, weekly payments of compensation must commence within three (3) working days of that decision. These payments are to commence with one weeks pay and continue for up to 8 weeks within which time the insurer will either accept or reject liability. If the claim is accepted, compensation owing must be offset by any amounts paid during the period of deferral. If the claim is rejected the deferral payment will cease. This payment is not recoverable from the injured worker.
- You must take all reasonable steps to provide the injured worker with suitable employment, and when necessary, so far as is practicable, participate in efforts to retrain the worker.
- If the employer is unable to provide the worker with suitable employment they, in consultation with the insurer, must refer the worker to the **alternative employer incentive scheme**.


Help

You can get help and more information from


NT WorkSafe
First Floor, Darwin Plaza
41 Smith Street, The Mall
Darwin NT 0800
Ph: (08) 8999 5585

NT WorkSafe
Peter Sitzler Building
67 North Stuart Highway
Alice Springs NT 0870
Ph: (08) 8951 8682

NT WorkSafe
Ground Floor, NTG Centre
First Street
Katherine NT 0850
Ph: (08) 8973 8416



Worker to fill in pages five and six of this document before giving to the employer to fill in page 8. It is the employer's responsibility to forward completed forms along with all other documentation to their insurance company



Insurer Claim No.

To the Insurer (mandatory field must be completed)

Date claim form received

____/____/____

Date claimant notified

____/____/____

Accept/Reject/Defer

Reason

Claim Number

1. About you

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname or Family Name

First or Given Names

Other names you have been known by eg maiden name, previous married or defacto name.

Sex: ☐ Male ☐ Female

Residential Address

Postal Address

If you change your address after lodging your claim, contact NT WorkSafe immediately to ensure timely notification of the decision on your claim.

Telephone No. Home

Work

Date of Birth ____/____/____ Age ____

Country of Birth

Language spoken at home

Marital status ☐ Single ☐ Married ☐ De facto

Worker's dependants ☐ Spouse ☐ Children

Other dependants (please specify)

2. About your job

Your occupation at the time of injury/disease.

Include here the main job you do and your job title.

Are you an Apprentice/Trainee? ☐ No ☐ Yes

Do you work ☐ Full time ☐ Part time

Are you ☐ Permanent ☐ Temporary ☐ Casual

Do you have other paid employment? ☐ No ☐ Yes

If Yes give details:

Full name and address of employer

3. About your claim

Where did the injury/disease occur? Please tick

- A ☐ At the workplace at which I am normally based.
B ☐ Working elsewhere
C ☐ While I was having a break
D ☐ Travelling to or from work
F ☐ Attending training school
J ☐ Travelling whilst on duty
☐ Other - give details below

Tell us the exact location or address where the injury/disease occurred.

When did your injury happen or you first noticed the disease?

Date

____/____/____

Time

____ am/pm

4. About the incident

Please tell us:

- ☐ What you were doing at the time.
- ☐ How the accident happened or what caused the disease.
- ☐ Include the object or substance that caused the accident eg grinder, drill etc.

5. About your injury/disease

Include here:

Part of body affected

Type of injury or disease eg fracture, burn etc.

If more than one injury which is the most serious?

6. Previous employers

Could the injury/disease have been contracted in previous employment?

☐ No

☐ Yes

Name of employer

Address

Period of employment

From

____/____/____

To

____/____/____

**PLEASE ENSURE PAGES 5 AND 6 ARE FILLED IN
BEFORE PASSING TO EMPLOYER**

7. Witnesses

The name and address of any persons who were present at the time of injury

8. Other information

Did you report the injury or disease to your employer?

No ☐ Reason

Yes ☐

Date injury/disease was reported

	/		/	
--	---	--	---	--

Time injury/disease was reported

	am/pm
--	-------

Name of the person you reported it to

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Position in the company

--

Did you stop work because of your injury or disease?

No ☐ Yes ☐

Date you stopped work

	/		/	
--	---	--	---	--

Time you stopped work

	am/pm
--	-------

Time you started work on that shift

	am/pm
--	-------

If you stopped, have you started back at work now?

No ☐ Yes ☐

Date you started back

	/		/	
--	---	--	---	--

Did you get medical treatment following your injury/disease?

No ☐ Yes ☐

Name and address of the doctor and/or health worker

Dates you were treated

	/		/	
--	---	--	---	--

	/		/	
--	---	--	---	--

Were you admitted to a hospital?

No ☐ Yes ☐

Name and address of hospital

Are you still receiving treatment?

No ☐ Yes ☐

Name of the person treating you

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What are you claiming for?

☐ Time off work (other than the day of injury)

☐ Medical expenses, surgical, rehabilitation, hospital expenses

If claiming for time off work you must provide an approved workers' compensation medical certificate or the claim will be invalid and not considered by the employer/insurer.

Have you suffered from a similar injury/disease before?

No ☐ Yes ☐

Name and address of the doctor who treated you

Type of injury/disease

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When did the injury/disease occur

	/		/	
--	---	--	---	--

Have you claimed workers compensation before?

No ☐ Yes ☐ SEE NOTE 1 ON PAGE 10

If Yes attach details as follows:

- When was the claim
- Who was your employer
- Who was the treating doctor

Declaration

I declare that the information I have shown in this form is true and correct and I have told you everything I know about the circumstances relating to my work related injury or disease.

SIGNATURE

--

Date handed to employer

	/		/	
--	---	--	---	--

If you are completing this form for the diseased or injured person give your name and address below.

A claim for weekly benefits for time off work must be accompanied by a copy of the approved medical certificate. IF THIS CERTIFICATE IS NOT ATTACHED, THE CLAIM FOR WEEKLY BENEFITS IS NOT VALID.

Authorisation for Medical and Personal Information

I consent to my employer's insurer (or my employer if my employer is an approved self-insurer or the Northern Territory Government self-insurer) and its appointed service providers collecting personal information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability. I consent to the disclosure of my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. I also consent to the disclosure of my personal details to NT WorkSafe which is authorised to use this information to fulfil its functions under the *NT Work Health Act*.

I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and their insurer, and any rehabilitation provider appointed by the insurer.


I understand I cannot withdraw or revoke this authority.

I am willing that a photostat copy of this authorisation be accepted with the same authority as the original.


Print name in full

Name _____ Signature **X** _____ Date _____

NOTE: THIS AUTHORISATION MUST BE COMPLETED, OTHERWISE YOUR CLAIM WILL NOT BE CONSIDERED.



Employer to fill in page 8. It is the employer's responsibility to forward the worker's and the employer's completed form along with all other documentation to the insurance company



EMPLOYER'S REPORT ON INCIDENT (ALL SECTIONS MUST BE COMPLETED)

9. Employer information

Registered business name

What is your "trading name" if different from business name?

ABN

ACN (if applicable)

Address for correspondence

Telephone

Fax

Name of the person who can be contacted in relation to this report

Position in the company

Date claim received from worker

10. Insurance details

What is your workers' compensation insurer's name?

What is the policy number?

What is the expiry date of the policy?

11. About the injured or diseased worker

What was the worker's gross weekly wage before the injury or disease?

Does this amount include any allowances? If yes attach details.

No ☐ Yes ☐

How many hours does the worker normally work each week?

Does the worker normally work overtime or shiftwork?

No ☐ Yes ☐

SEE NOTES 2 & 3 ON PAGE 10

Where within your establishment does the worker normally work?

NOTE: Your answer here must tell us the actual section and ADDRESS of the workplace where the worker does the majority of his or her work. If the worker works at multiple locations, tell us where the worker is normally based.

How many people are employed at this particular location? (ie, at the address above, at the present time)

1 - 4 ☐

50 - 99 ☐

5 - 9 ☐

100 - 199 ☐

10 - 19 ☐

200 - 499 ☐

20 - 49 ☐

500 + ☐

When was the worker first employed by you?

Has the worker provided you with an Australian Business Number (ABN) in writing?

No ☐ Yes ☐

If yes, what is the worker's ABN?

Give details of other circumstances which would assist the insurer to assess the claim (eg Do you query the validity of the claim?)

No ☐ Yes ☐

In my opinion

What is the type of industry at the establishment where the worker normally works?

SEE NOTE 4 ON PAGE 10

12. More than one person injured

Was more than one person injured in the incident described in Section 4?

No ☐ Yes ☐

Please describe what happened, including the date and address where this happened.

13. Reportable accident

Was this incident reported to NT WorkSafe as a notifiable accident?

No ☐ Yes ☐

SEE NOTE 5 ON PAGE 10

If yes, date notified:

Declaration

I declare that all the information I have provided in this report is true and correct and I have told you everything I know about the circumstances surrounding this worker's injury or disease.

Signature

Date

Name of the person who has filled in this form

Position in the company

Information for the injured worker

(Important: keep this information for your records for the duration of your claim)

What are your entitlements

Once your claim has been **accepted** your employer is required to pay:

- **Weekly payments** – may commence within 3 working days of the insurer accepting the claim. A worker is entitled to receive their normal weekly earnings for the first twenty-six (26) weeks of total or partial incapacity.
- If after the first 26 weeks you are totally or partially incapacitated you will normally be paid at 75% of your loss of earning capacity. Minimum and maximum provisions may apply.
- **Medical expenses** – reasonable hospital, medical and ancillary expenses resulting from your work related injury.
- **Vocational rehabilitation expenses** – if your doctor, employer and you agree specialist services are required to help your return to work, an approved vocational rehabilitation provider will assess your situation and provide assistance if appropriate.
- **Travelling expenses** – reasonable travelling and accommodation expenses incurred while obtaining medical treatment.
- **Other services** - The provision of home modifications, vehicle modifications and household and attendant care services as are reasonable and necessary.
- **Permanent Impairment** – If you are left with a permanent impairment as a result of a work related injury or illness there is provision under the *NT Work Health Act* for a payment in respect of that permanent impairment.
- For more detailed information refer to Information Bulletin 13.01.16. (www.worksafe.nt.gov.au)

How to maintain your claim

- **Regular contact** – between you, your doctor and your employer/insurer is important and will assist the overall management of your claim.
- **Ensure** – you provide your employer with all medical certificates from your treating doctor as quickly as possible. You should keep a copy for your records.
- **Discuss** – any concerns you have with your employer, insurer, doctor or NT WorkSafe.
- **Your employer** – and doctor may discuss your injury and your return to work options.
- **Medical Treatment** – Where practicable, appointments should be made outside working hours. Any time loss in a week (during working hours) counts as a full week, towards the 26 weeks total.

Your return to work

- You must cooperate with reasonable treatment, rehabilitation and return to work programs.
- Your employer should take all reasonable steps to provide you with suitable employment, however if your employer is unable to provide suitable duties they, in consultation with the insurer, must refer you to the alternative employer incentive scheme to assist you in gaining suitable alternative employment. For more information refer to the Information Bulletin 13.02.08.
- You are also required to inform your employer if you commence employment elsewhere, or circumstances change in a way which may affect your entitlements.

Disputes

- Should you disagree with any decision made by the insurer regarding your workers' compensation claim, contact NT WorkSafe for information on dispute resolution procedures by phoning 1800 019 115, or visit our website at www.worksafe.nt.gov.au.

NOTES ON CLAIM FORM

FOR THE WORKER

NOTE 1

This information is required to determine if the present injury or disease may be related to a previous incident.

FOR THE EMPLOYER

NOTE 2

If worker has no fixed hours and is employed on a casual basis, please state the average number of hours worked per week. If no fixed hourly rate of pay applies then the earnings over the same period must also be averaged. (Where possible, please provide a copy of previous pay sheet/slip to substantiate regular hours.)

NOTE 3

If a regular or fixed pattern of overtime and/or shifts are worked, you must confirm in writing the basis on which it is worked ie for how long has the worker been working these shifts and what is the regularity.

NB Do not let the provision of this information cause delay in giving this claim to your insurer. However, you will need to discuss these details, with your insurer, as soon as practicable after giving them the claim.

NOTE 4

You must state the main type of activity, business or service you provide in which the injured worker was involved. You do not put the actual occupation of the worker: eg if you are a gold mining company and the injured worker is a driver, you would put down 'gold mining'.

NOTE 5

Regulation 46 of the Work Health (OH&S) Regulations requires that the following accidents are reported to NT WorkSafe as soon as possible.

An accident or occurrence:

- causing the death of a person;
- causing or, on the basis of medical advice, appears likely to cause a worker to be absent from work for 5 or more working days;
- where a worker receives an electric shock;
- where a worker is injured and admitted to hospital as an in-patient following exposure to a hazardous substance;
- where a person, other than a worker, is injured as a result of a workplace activity or by designated plant;
- involving the collapse, overturning or failure of a load bearing part of a lift, crane, hoist, lifting gear or scaffolding;
- involving the collapse of shoring or an excavation which is more than 1.5 metres deep;
- involving the unplanned collapse of a building or structure or part of a building or structure;
- involving an explosion or fire that results in designated plant being inoperative or normal work being suspended, for more than 24 hours;
- involving an unplanned contact between plant and a live electrical conductor; and
- involving a malfunction or failure of personal protective equipment which affects the health and safety of a person.

BENEFITS ARE:

Weekly benefits for incapacity, costs of medical treatment, reasonable rehabilitation costs, benefits for permanent impairment, and death benefits.