

WORKERS' COMPENSATION CLAIM FORM 2B (REG 6AA)

SECTION 178(1)(b) OF THE WORKERS' COMPENSATION AND INJURY MANAGEMENT ACT 1981

Employer - please tear off this front page and give to the injured worker.

TO THE INJURED WORKER: Workers' Compensation can be claimed if you have had time off work or incurred any medical costs because of a work related injury.
Please read this fact sheet and keep it for future reference.

One of the primary goals of the workers' compensation and injury management system (the system) is, where possible, to make provision for the management of workers' injuries in a manner that is directed at enabling injured workers to return to work. The system also provides workers who have sustained a work related injury with weekly payments of workers' compensation and payment of reasonable medical and other expenses.

When can you make a claim for workers' compensation?

- You can make a claim for workers' compensation if you suffer any of the following:
 - a personal injury by accident arising out of, or in the course of employment, or while acting on the employer's instructions;
 - a disabling disease; and/or
 - a disease contracted in the course of employment, or the recurrence or aggravation of a pre-existing disease where the employment contributed to a significant degree;

and any one of the above results in **time off work** or **requires medical treatment**.

Reportable Accidents

It is a requirement of the *Occupational Safety and Health Act 1984* that an employer whose employee suffers a reportable injury must notify WorkSafe WA by telephoning 9327 8800.

Notifiable accidents include those accidents that result in:

- the death of an employee;
- a fracture of any bone in the arm (other than the wrist or hand);
- a fracture of any bone in the leg (other than in the ankle or foot);
- amputations including and greater than a finger or toe joint;
- the loss of sight of an eye; and
- any other injury that a medical practitioner believes is likely to prevent the employee being able to work for 10 consecutive days.

Note that some diseases are also notifiable to WorkSafe WA.

Under the *Mining Safety and Inspection Act 1994* any injury that prevents a worker from performing his or her ordinary duties at a site designated as a mining operation must be reported to the Resources Safety Division of the Department of Consumer and Employment Protection. The Resources Safety Division can be contacted by telephoning 9222 3438.

Where you can obtain more information

For information regarding your workers' compensation claim please contact:

WorkCover WA

2 Bedbrook Place
SHENTON PARK WA 6008

WorkCover WA Infoline: 1300 794744

WorkCover WA website: www.workcover.wa.gov.au

Facsimile: (08) 9388 5550

Hearing Impaired: TTY (08) 9388 5537

Interpreter services are available by prior arrangement

Email: postmaster@workcover.wa.gov.au

WorkCover WA provides **seminars for injured workers** which inform them of their rights and obligations under the *Workers' Compensation and Injury Management Act 1981*. You can book a place at a seminar by telephoning the WorkCover WA Infoline on 1300 794 744.

How can you claim?

- You must give notice to your employer as soon as you can of the occurrence that led to your injury.
- See a **doctor of your choice** and ask for a First Medical Certificate (FMC).
- You must fill in this claim form (2B) and attach a FMC if you are claiming weekly benefits and/or reasonable medical expenses.
- Both this claim form and a FMC (given to you by your treating doctor) must be given to your employer as soon as possible.
- Your employer has 3 days in which to give your claim form and your FMC to their insurer.
- After receiving your claim the insurer has 14 days to respond to you. If your employer is a self-insurer then they have 17 days in which to respond to you after receiving your claim.
- The insurance company may assign an assessor to investigate your claim. It is your choice whether you agree to being interviewed by the assessor, and a person of your choice may accompany you.
- If liability is disputed or deferred, or you do not hear from the insurer within 17 days of making the claim on your employer, then you can go to the **Dispute Resolution Directorate** to have the matter resolved.
- You can contact the **WorkCover WA Infoline** on **1300 794 744** for further information.

What are your entitlements?

Once your claim has been accepted your employer is required to pay (*up to prescribed limits*):

- **weekly payments of workers' compensation** paid on your normal pay day for any period that your doctor has certified that you required time off work (*call the WorkCover WA Infoline for information on the calculation of your weekly payments if necessary*).
- **reasonable medical expenses** for hospital, medical and other expenses resulting from your work related injury. Remember you are entitled to **receive treatment from a doctor of your choice**.
- **reasonable vocational rehabilitation expenses** if your doctor, employer and you agree specialist services are required to help your return to work. **An approved rehabilitation provider of your choice** can be requested to assess the situation and provide assistance if appropriate.
- **reasonable travel and accommodation expenses** incurred while obtaining medical treatment.

How to maintain your claim

- Regular contact between you, your doctor and your employer is important and will assist the overall management of your claim.
- Make sure your doctor gives you a WorkCover WA brochure. This outlines what you should know about the system and provides information on the return to work process.
- Ensure you provide your employer with all medical certificates from your treating doctor as quickly as possible. You may wish to keep a copy for your records.

When can I return to work?

- Your employer may have to develop a return to work program and take reasonable steps to ensure that you agree with it. A return to work program is required if:
 - your treating doctor advises your employer to do so; or
 - your treating doctor has signed a medical certificate saying that you are fit for duties other than your normal job on a full-time basis.
- If you become partially or totally fit for work within 12 months from the day you became entitled to receive weekly payments of compensation, your employer must provide you with your pre-injury job, if reasonably practicable, or another job comparable in status and pay to your pre-injury position for which you are qualified and capable of performing.
- Under section 59(2) of the *Workers' Compensation and Injury Management Act 1981* you must notify your employer in writing within 7 days if you commence work with another employer after making a claim or while receiving weekly payments of compensation.

Am I entitled to other Benefits?

Depending on whether you qualify there may be other options available to you. Contact the WorkCover WA Infoline on **1300 794 744** for further information.

Important Notice

Workers who have an open workers' compensation claim are encouraged to ensure that their employer or the employer's insurer are notified of any change of address.

WORKERS' COMPENSATION CLAIM FORM 2B (REG 6AA)

SECTION 178(1)(b) OF THE WORKERS' COMPENSATION AND INJURY MANAGEMENT ACT 1981

INSTRUCTIONS FOR THE INJURED WORKER

- You must complete the blue section of this form if you wish to claim workers' compensation.
- Please use a ballpoint pen.
- Ensure the original copy and duplicate are complete and legible.
- Once completed give this form and your first medical certificate to your employer as soon as you can.

TO THE EMPLOYER

- 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.
- Make sure you complete the employer details section (**red box**).
- Give the **information tear off** section at the front of the claim form to **the injured worker**.
- Forward this form, medical certificate(s), medical accounts (*if any*), and the employer's report **to your insurance company within 3 full working days of receipt from the worker** [Section 57A(2)].
- For a motor vehicle accident a journey report form (*available from your insurance company*) should also be completed and returned.
- Review the First Medical Certificate's "**Doctor/Employer Contact**" section. If the doctor has indicated the worker will be off work for **3 days or more**, or is **unable to return to normal duties**, she/he will be expecting **contact from you** to discuss return to work options.
- If the **doctor has requested contact from you** on the First Medical Certificate, complete the "**Details to be Provided to Doctor**" section of the claim form (*page 7*), and **fax it to the doctor**.
- Forward subsequent medical certificates and accounts to your insurance company as soon as you receive them.
- You are required to keep an **injured worker's job open for 12 months from the day the worker became entitled to receive weekly payments of compensation**. If the injured worker becomes **partially or totally fit for work within 12 months, from the day they became entitled to receive weekly payments of compensation, you must provide them with their pre-injury job, if reasonably practicable**, or another job comparable in status and pay to their pre-injury position for which they are qualified and capable of performing.
- **A notice of intention** to dismiss a worker is to be given to the worker and to WorkCover WA not less than 28 days before the dismissal is to take effect and is to be in the form prescribed and contain the information prescribed.

PRIVACY AMENDMENT (PRIVATE SECTOR) ACT 2000

Your employers' insurance company needs to collect, use and disclose personal information to assess, investigate and otherwise deal with your claim. If you do not provide the information requested, this may affect the insurer's ability to do those things.

By providing your personal information, you consent to the insurer:

- (a) collecting and using your personal information for the purpose of assessing, investigating and otherwise dealing with your current or any subsequent claim; and
- (b) for these purposes, disclosing personal information (*on a confidential basis*) to and collecting personal information from:
 - (i) your employer, the insurer's related entities, its investigators, auditors, medical service providers or any other party providing services to the insurer or any agent of these;
 - (ii) other insurers, insurance intermediaries, government regulators or insurance reference bureaux; or
 - (iii) lawyers and law enforcement agencies.

General information on Workers' Compensation and Injury Management can be obtained from WorkCover WA, 2 Bedbrook Place, Shenton Park WA 6008, Telephone: Workcover WA Infoline 1300 794 744, Facsimile (08) 9388 5550, TTY (*for the hearing impaired*) (08) 9388 5537. www.workcover.wa.gov.au

Employer details

To be completed by employer after receipt from the worker and forwarded to the insurer within 3 full working days.

Office Use Only

Name of policy holder		Insurance Co.
Address		
Suburb/town	Postcode	Policy No.
Full name of employer:		WorkCover No.
Trading as: (e.g. E.J. Imports Browns Pharmacy)		
Address of worker's usual workplace or base	Postcode	Claim No: Insurer/Self Insurer to complete
Major activity of workplace: (e.g. sheep or grain farming; aluminium window screen manufacturing)		ANZSIC CODE -

Injured worker details

Surname	Dr/Mr/Mrs/Miss/Ms	Date of birth	Age	Sex
Other names		/ /		Male/Female
Address		If you have difficulty understanding English, what is your preferred language?		
Phone No.	Postcode	At the time of the occurrence were you working as a:		
Occupation (e.g. first class welder; accounts clerk)		- direct employee?	<input type="checkbox"/>	1
Main tasks or duties performed? (e.g. welding of high pressure steam pipes; recording and paying accounts)	ASCO	- working director?	<input type="checkbox"/>	2
.....		- contractor?	<input type="checkbox"/>	3
		- employee of contractor?	<input type="checkbox"/>	4
		- sub-contractor?	<input type="checkbox"/>	5
		- other?	<input type="checkbox"/>	6
		full time <input type="checkbox"/> F part time <input type="checkbox"/> P		
		permanent <input type="checkbox"/> P temporary <input type="checkbox"/> T casual <input type="checkbox"/> C		

Occurrence details

Day of occurrence	Date	Time
	/ /	: am/pm
At what address did the occurrence occur?		
When did you have to stop working?	Date	Time
	/ /	: am/pm
Were you:	<input type="checkbox"/> A	<input type="checkbox"/> E
• Working - at Normal Workplace	<input type="checkbox"/> B	• On Work Break - at Normal Workplace
• Working - Away from Normal Workplace	<input type="checkbox"/> C	• On Work Break - Away from Normal Workplace
• Working - Road Traffic Accident	<input type="checkbox"/> D	• Other Duty Status
• Commuting/Journey	
What actually happened and what caused the occurrence? Include:		Mechanism
(i) what action was involved (e.g. - fall, caught between, struck by moving object)		
		Agency
(ii) what object/machine/substance was involved (e.g. petrol fumes, wooden door frame)		
		Nature
Describe: i) the most serious injury or disease which was caused by the occurrence (e.g. fracture, burn, cut, abrasion)		Bodily Location
ii) bodily location of the injury or disease (e.g. upper arm, ankle, eye)		

Insurer/Self-insurer to complete	Insurer/Self-insurer's Date Stamp
Estimated time off work -	
• less than 1 day <input type="checkbox"/>	
• 1-4 work days (inclusive) <input type="checkbox"/>	
• 5-9 work days (inclusive) <input type="checkbox"/>	
• 10-20 work days (inclusive) <input type="checkbox"/>	
• more than 20 work days <input type="checkbox"/>	
• fatality <input type="checkbox"/>	
• Has employer faxed medical practitioner? <input type="checkbox"/>	

Occurrence report

Where did the occurrence occur? (e.g. store room, machinery shop)

What were you doing at the time of the occurrence?

What were the normal working hours for that day?

Starting time

: am/pm

Finishing time

: am/pm

When did you first report the occurrence?

Date

/ /

Time

: am/pm

To whom did you report the occurrence?

Name/Title

If the occurrence was not reported immediately, state the reason:

Name and address of witness(es) to the occurrence:

Medical attention/history – this event

1. When did you first seek medical attention?

Date

/ /

Time

: am/pm

2. If not immediately, state reason:

3. Was the part of the body affected or injured by this occurrence healthy before the occurrence? If not, give details:

Medical attention/history – similar or related previous events

4. Is the present injury totally attributable to this occurrence? If not, give details:

5. Give details of any similar injury prior to this occurrence:

6. Name & address of usual medical practitioner, and any person who has treated you for a similar injury:

Other or previous claims

1. Is compensation being claimed from any other source? Yes/No

Yes/No

If so, from whom?

2. Give details of similar or related previous workers' compensation claims:

Name & address of employer	Name of insurer (if known)	Nature of injury, disease or other claim

Injured worker's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this day of Year.....

Signature of workerSignature of witness.....

Consent Authority (to be signed at the option of the worker) 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 with their insurer.

Dated this day of Year.....

Signature of workerSignature of witness.....

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE AUTHORITY ABOVE MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM.

Privacy Amendment (Private Sector) Act 2000

Consent Authority (To be signed at the option of the worker)

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information, about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*.

I have read all the information on this form regarding the Privacy Amendment (Private Sector) Act 2000 and I consent to the Insurer dealing with my personal information in the manner described.

Signed: Date:.....

Name: Witness: (name & signature).....

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SECTION 178(1)(b) OF THE WORKERS' COMPENSATION AND INJURY MANAGEMENT ACT 1981

Employer Please Complete

If the First Medical Certificate indicates the injured worker will be absent from the workplace for more than 3 working days and/or is unable to return to normal duties:

- please complete this section and fax it to the medical practitioner who provided the worker's First Medical Certificate **within 2 working days.**

DETAILS TO BE PROVIDED TO MEDICAL PRACTITIONER

ATTENTION Dr. _____ **Fax No.** _____

WORKER'S DETAILS

Name in full:
Address:
Date of birth: Occupation: Telephone:

INSURER'S DETAILS

Name of insurer:
Contact person: Telephone:

EMPLOYER'S DETAILS

Trading name: Telephone:
Address of worker's usual workplace:
Employer contact for liaison with medical practitioner:
Role within organisation: Telephone: Fax:

ALTERNATIVE DUTIES FOR WORKER

The above nominated contact is willing to discuss alternative duties and / or appropriate return to work options with the medical practitioner. Yes No

This organisation can provide alternative duties, which are outlined below. Yes No

This organisation has a return to work program for injured workers. Yes No

Injured worker's pre-accident duties: Possible alternative duties:
.....
.....
.....
.....
.....
.....
.....
.....

Signature:..... **Date:**

Please complete all sections of this form

Employer details

To be completed by employer after receipt from the worker and forwarded to the insurer within 3 full working days.

Office Use Only

Name of policy holder		Insurance Co.
Address		
Suburb/town	Postcode	Policy No.
Full name of employer:		WorkCover No.
Trading as: (e.g. E.J. Imports Browns Pharmacy)		Claim No: Insurer/Self Insurer to complete
Address of worker's usual workplace or base	Postcode	
Major activity of workplace; (e.g. sheep or grain farming; aluminium window screen manufacturing)		ANZSIC CODE -

Injured worker details

Surname	Dr/Mr/Mrs/Miss/Ms	CITIZEN	Date of birth	Age	Sex
Other names		JOHN	01/04/80	29	Male/Female
Address		1 SAMPLE ST	If you have difficulty understanding English, what is your preferred language?		
		SAMPEVILLE Postcode 6000			
Phone No.			At the time of the occurrence were you working as a:		
Occupation (e.g. first class welder; accounts clerk)		STOREMAN	- direct employee?	<input checked="" type="checkbox"/> 1	
Main tasks or duties performed? (e.g. welding of high pressure steam pipes; recording and paying accounts)	ASCO		- working director?	<input type="checkbox"/> 2	
			- contractor?	<input type="checkbox"/> 3	
			- employee of contractor?	<input type="checkbox"/> 4	
			- sub-contractor?	<input type="checkbox"/> 5	
			- other?	<input type="checkbox"/> 6	
			full time <input checked="" type="checkbox"/> F part time <input type="checkbox"/> P		
			permanent <input type="checkbox"/> P temporary <input type="checkbox"/> T casual <input type="checkbox"/> C		

Occurrence details

Day of occurrence	MONDAY	Date	20/04/09	Time	08:00 am/pm
At what address did the occurrence occur?					
99 MAIN RD, SAMPLEVILLE, WA 6000					
When did you have to stop working?		Date	20/04/09	Time	08:00 am/pm
Were you:	<ul style="list-style-type: none"> Working - at Normal Workplace <input checked="" type="checkbox"/> A Working - Away from Normal Workplace <input type="checkbox"/> B Working - Road Traffic Accident <input type="checkbox"/> C Commuting/Journey <input type="checkbox"/> D 	<ul style="list-style-type: none"> On Work Break - at Normal Workplace <input type="checkbox"/> E On Work Break - Away from Normal Workplace <input type="checkbox"/> F Other Duty Status <input type="checkbox"/> O 			
What actually happened and what caused the occurrence? Include:					Mechanism
(i) what action was involved (e.g. - fall, caught between, struck by moving object)					Agency
Lifting boxes off conveyor + placing them on to pallet					Nature
(ii) what object/machine/substance was involved (e.g. petrol fumes, wooden door frame)					Bodily Location
boxes / conveyor / pallet.					
Describe: i) the most serious injury or disease which was caused by the occurrence (e.g. fracture, burn, cut, abrasion)					
torn bicep muscle					
ii) bodily location of the injury or disease (e.g. upper arm, ankle, eye)					
right arm					

Insurer/Self-insurer to complete	Insurer/Self-insurer's Date Stamp
<ul style="list-style-type: none"> Estimated time off work - less than 1 day <input type="checkbox"/> 1-4 work days (inclusive) <input type="checkbox"/> 5-9 work days (inclusive) <input type="checkbox"/> 10-20 work days (inclusive) <input type="checkbox"/> more than 20 work days <input type="checkbox"/> fatality <input type="checkbox"/> Has employer faxed medical practitioner? <input type="checkbox"/> 	

Occurrence report

Where did the occurrence occur? (e.g. store room, machinery shop) **DESPATCH**

What were you doing at the time of the occurrence? **lifting boxes off conveyor onto pallet**

What were the normal working hours for that day? Starting time **06:00 (am/pm)** Finishing time **03:00 am(pm)**

When did you first report the occurrence? Date **20/04 109** Time **08:00 (am/pm)**

To whom did you report the occurrence? Name/Title **Supervisor. B. Awaie.**

If the occurrence was not reported immediately, state the reason: **-**

Name and address of witness(es) to the occurrence: **A. FRIEND. 1 MATE ST, MATETOWN, 6000**

Medical attention/history - this event

1. When did you first seek medical attention? Date **20/04 109** Time **08:00 (am/pm)**

2. If not immediately, state reason:

3. Was the part of the body affected or injured by this occurrence healthy before the occurrence? If not, give details: **YES.**

Medical attention/history - similar or related previous events

4. Is the present injury totally attributable to this occurrence? If not, give details: **YES**

5. Give details of any similar injury prior to this occurrence:

6. Name & address of usual medical practitioner, and any person who has treated you for a similar injury:

Other or previous claims

1. Is compensation being claimed from any other source? **Yes/No** If so, from whom?

2. Give details of similar or related previous workers' compensation claims:

Name & address of employer	Name of insurer (if known)	Nature of injury, disease or other claim

Injured worker's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this **21** day of **April** Year **2009**
 Signature of worker **[Signature]** Signature of witness

Consent Authority (to be signed at the option of the worker) 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 with their insurer.

Dated this **21** day of **April** Year **2009**
 Signature of worker **[Signature]** Signature of witness

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE AUTHORITY ABOVE MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM.

Privacy Amendment (Private Sector) Act 2000

Consent Authority (To be signed at the option of the worker)

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information, about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*.

I have read all the information on this form regarding the Privacy Amendment (Private Sector) Act 2000 and I consent to the Insurer dealing with my personal information in the manner described.

Signed: Date:

Name: Witness: (name & signature)