Workers Compensation

Recurrence of disability claim form

PROVIDENT INSURANCE SERVICES

Claim no.

To be completed where an injured person has lost further time following a return to work or where there has been a renewal of treatment of the original disability. Attach medical certificates and reports if available.

The injured person

Full name

Address

Current employer

Employer at time of original disability/injury

Type of injury or condition

Date of original disability/injury / /

Date of recurrence / /

Date of return to work (if further time lost)

Date medical certificate received

Date of recurrence claim form received / /

Details of recurrence

Were you performing your usual work duties when the latest onset of symptoms of incapacity occurred? Yes ☐ No ☐

If yes, what specific duties caused the recurrence?

If no, where were you and what were you doing?

Were there any witnesses to the onset of further symptoms? Yes ☐ No ☐

If yes, provide names, addresses and attach statements.

Was the onset of further symptoms reported? Yes ☐ No ☐

If Yes, when / / To whom?

What symptoms, if any, were you experiencing just prior to the latest onset?

What medical treatments were you receiving prior to the latest onset of symptoms? State names of treating doctors and dates of treatment.

If you changed employment since your original disability, please provide: Names of employers, date worked and occupation.

How to return this form

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› Fax: (08) 9389 5852

› Post: Provident Insurance Services

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How to contact us

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