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

SECTION 84(1)(b) OF THE WORKERS' COMPENSATION AND REHABILITATION ACT 1981

**Employer please give this tear off factsheet 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 or disease.

**Please read this factsheet and keep for future reference.**

## How to claim

- If you believe you have been injured at work **tell your employer** or supervisor as soon as you can.
- Fill in a "Notice of Occurrence of Disability" form (available from your employer), and **record the injury** in your employer's Accident Report Book as soon as practicable.
- **See a doctor of your choice** and ask for a **First Medical Certificate.**
- Fill in the enclosed Workers' Compensation Form (Form 2B) and give it and your First Medical Certificate to your employer **as soon as you can.**
- If you can't fill in this form yourself you may ask someone else to help you.

## What happens next ?

- Your employer must send your claim to his/her insurance company within **3 working days** of receiving it from you.
- **The insurance company must advise** you (in writing) if your claim is accepted, disputed, or that more time to make a decision is needed, within **14 days** of receiving the claim from your employer.
- If your employer is a **self-insurer** they must, within **17 days** of receiving the claim from you, start your weekly payments if the claim is accepted, or advise you (in writing) that the claim is rejected or that more time for a decision is needed.
- 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.
- Your employer and doctor may discuss your injury and your return to work options.

## What are your entitlements?

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

- **Weekly payments** - paid on your normal pay day for any period that your doctor has certified you require time off work. Call WorkCover for information on the calculation of your weekly payment if necessary.
- **Medical expenses – reasonable** hospital, medical and ancillary expenses resulting from your work related injury. You are entitled to receive **treatment from a doctor of your choice.**
- **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 **of your choice** can be requested to assess your situation and provide assistance, if appropriate.
- **Travelling expenses -** reasonable travelling 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 injury management 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.
- An injury management system is in place and it is important you understand your rights and responsibilities in relation to your return to work.
- Discuss any concerns you have with your employer and doctor. If they cannot answer your questions, contact WorkCover WA's Infoline. **WorkCover WA** is the government authority that administers the workers' compensation system in Western Australia.
- WorkCover WA is available as an independent third party to help answer your questions about how the workers' compensation system works.
- WorkCover WA runs free information seminars for injured workers every 3 weeks aimed at helping you understand the workers' compensation system. Contact WorkCover WA to arrange your attendance.

**Should you have any problems with any aspect of your claim** contact your employer or union, or **WorkCover's Infoline** on: 9388 5555 (metro), 1800 670 055 (country) or TTY (for the hearing impaired) 9388 5537. If necessary, an Interpreter can be arranged by WorkCover.

## Your right to return to work

If you become **partially or totally fit for work within 12 months, from the day you become 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.

**Please Note** Under section 59(2) of the *Workers' Compensation and Rehabilitation 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.

## Weekly payments of workers' compensation

- Weekly payments for all workers are now capped to a maximum of $1021.60 (amount current until 30 June 2003). This amount will be indexed annually.
- Depending on the circumstances of your pay arrangements, your weekly payments may be subject to a "step down" after the first four weeks of your claim.

## Undecided or disputed claims

- If your claim is **disputed**, or **more time to make a decision** is required, the insurer must advise you (within 14 days of receipt of the claim) why your claim is disputed or that more time is needed.
- **If your claim is disputed** you may apply to the **WorkCover Conciliation and Review Directorate** for conciliation.
- **If your claim requires more time**, the insurer is allowed a further **10 days** to make a decision. If, at the end of this time, your claim is disputed or remains undecided the matter may be referred to the Conciliation and Review Directorate (for example, a dispute may relate to weekly benefits, medical opinions or rehabilitation).

## Conciliation and Review Directorate

The WorkCover **Conciliation and Review Directorate** is a dispute resolution body which provides an informal forum for **resolving disputes** over **Workers' Compensation or Rehabilitation** which may occur between workers and employers. The dispute resolution procedure involves up to four stages:-

- **Conciliation** - To **apply for conciliation** a referral for conciliation form must be completed, signed and lodged with the Directorate. Parties do not require legal representation at the conciliation stage, but if all parties and the conciliation officer agree, then a person may be represented.
- **Review** - Review officers hear and determine disputes not resolved by conciliation. Parties are entitled to be represented by a legal practitioner at any proceedings before a review officer if all parties agree or if the review officer believes a question of law is likely to be raised or argued.
- **Compensation Magistrate's Court** – hears and determines matters referred by a Review Officer on a question of law, hears appeals on questions of law only against decisions made by Review Officers, hears and determines any application made to it which is permitted by the Act, and any complaints for offences under the Act.
- **Supreme Court** - hears and determines appeals on questions of law only against a compensation magistrate's court.
- **Medical Assessment Panels** - a conciliation or Review Officer or a Compensation Magistrate may refer **medical questions** such as conflicting opinion between the doctors involved in a claim, to a medical assessment panel for determination.

For more information on **dispute resolution procedures**, contact the **Directorate on (08) 9324 6666, Country calls – 1800 633 108.**

## Common law election

The following information may assist workers who wish to retain their right to take action for common law damages against their employers, independently of the Act, in respect of a disability suffered by a worker.

If your degree of disability is less than 16 % the courts are not able to award common law damages against your employer in respect of that disability.

- If your degree of disability is not less than 16 % and less than 30% (what is known as a "significant disability") and you wish to retain the right to seek damages against your employer at common law in respect of that disability you must make an **"election"** . This must normally be done before your **"termination day"** (which in most cases is 6 months after commencement of weekly compensation payments.
- If your degree of disability is 30% or more there is no requirement for you to make an election.
- If you make an election to retain the right to seek common law damages, compensation under the Act is not payable from the date the election is registered.
- An **election** can only be made if you and your employer agree that your level of disability is not less than 16 % and less than 30%, or if your employer does not agree and you have referred the matter to the Director of Conciliation and Review, along with supporting medical evidence and your degree of disability has been determined to be not less than 16 % and less than 30%. Such a referral must be lodged **not less than 21 days before the termination day.** In these circumstances, your election may be made within 14 days after the dispute as to your degree of disability has been resolved.
- In certain very specific and limited circumstances, it may be possible to apply for an extension of the time to make an election. In these cases, you must, in the first instance apply for the extension at least 21 days before your termination day
- The prescribed forms for making elections, requesting extensions and referring questions on the degree of disability are available from the Conciliation and Review Directorate at 15 Rheola Street, West Perth WA 6005. Telephone 93246666, Country calls: 1800 633 108.,

**General information on Workers' Compensation and Rehabilitation** can be obtained from **WorkCover WA**, 2 Bedbrook Place, Shenton Park WA 6008, **Telephone: (08) 9388 5555, Country calls 1800 670 055, Facsimile: (08) 9388 5550, TTY (for the hearing impaired): (08) 9388 5537, www.workcover.wa.gov.au**

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

SECTION 84I(1)(b) OF THE WORKERS' COMPENSATION AND REHABILITATION 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 **within 3 full working days of receipt from the worker to your insurance company** [Section 57A(2)].
- For a motor vehicle accident and 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 reasonable practicable**, or another job comparable to status and pay to their pre-injury position for which they are qualified and capable of performing.
- **Report accidents notifiable** under the Occupational Health, Safety and Welfare Acts to WorkSafe Western Australia on 9327 8777.

## PRIVACY AMENDMENT (PRIVATE SECTOR) ACT 2000

Your employer's 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 but this may affect the insurer's ability to do those things.

1. By providing your personal information, you consent to the insurer –

   (a) collecting and using your personal information for the purposes 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 Rehabilitation can be obtained from WorkCover WA, 2 Bedbrook Place, Shenton Park WA 6008, Telephone: (08) 9388 5555, Country calls 1800 670 055, Facsimile (08) 9388 5550, TTY (for the hearing impaired) (078) 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*

| | | |
|---|---|---|
| Name of policy holder | | Insurance Co. |
| Address | | |
| Suburb/town | Postcode | Policy No. |
| Full name of employer:<br>Trading as:<br>e.g. E.J. Imports<br>Browns Pharmacy; | | WorkCover No. |
| Address of worker's usual Workplace or base | Postcode | WC …….. |
| Major activity of workplace:<br>e.g. sheep or grain farming;<br>Aluminium window screen manufacturing | | Claim No:<br>Insurer/Self-insurer to complete |
| Office use only ANSIC CODE | | |

## Injured worker details

| | | | |
|---|---|---|---|
| **Surname** | Mr/Mrs/Miss/Ms | Date of birth / / / Age | Sex Male/Female |
| **Other names** | | If you have difficulty understanding English, what is your preferred language? …… | |
| **Address** | | **At the time of the occurrence were you working as a:** | |
| | Postcode | - **direct employee?** ☐ 1 | |
| **Phone No.** | | - **working director?** ☐ 2 | |
| | | - **contractor?** ☐ 3 | |
| | | - **employee of contractor?** ☐ 4 | |
| | | - **sub-contractor?** ☐ 5 | |
| | | - **other?** ☐ 6 | |
| | | **full time ☐ F part time ☐ P** | |
| | | **permanent ☐ P temporary ☐ T casual ☐ C** | |

Occupation e.g. first class welder, accounts clerk

Main tasks or duties performed? e.g. welding of high pressure steam pipes; recording and paying accounts …… ASCO

## 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- working, and:**

- **at your usual workplace?** ☐ A
- **at a diiferent workplace?** ☐ B
- **in a road traffic accident** ☐ C
- **travelling between home and work?** ☐ D

**-on a work break and:**

- **at your usual workplace** ☐ E
- **-not at your usual workplace?** ☐ F
- **doing something else? (please describe below)** ☐ O

……

What actually happened and what caused the occurrence? Include:
(i) what action was involved, e.g. – fall, caught between, struck by moving object

(Ii) what object/machine/substance was involved, e.g. petrol fumes, wooden door frame

Mechanism

Agency

Nature

Bodily Location

Describe: i) the most serious injury or disease caused by the occurrence, e.g. fracture, burn, cut, abrasion

ii) bodily location of the injury or disease, e.g. upper arm, ankle, eye

| Insurer/Self-insurer to complete | | | |
|---|---|---|---|
| Estimated time off work – | | • 10-20 work days (inclusive) | ☐ |
| • less than 1 day | ☐ | • more than 20 work days | ☐ |
| • 1-4 work days (inclusive) | ☐ | • fatality | ☐ |
| • 5-9 work days (inclusive) | ☐ | • Has employer faxed medical practitioner | ☐ |

Insurer/Self-insurer's Date Stamp

## 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 or disability totally attributable to this occurrence? If not, give details: | |
| 5. Give details of any similar injury or disability prior to this occurrence: | |
| 4. Name & address of usual medical practitioner, and any person who has treated you for a similar disability: | |

## 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 Rehabilitation 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. I understand that I can only claim damages at common law for my injury against my employer if it is agreed or determined that my degree of disability is not less than 16%. I also understand if my disability is assessed to be not less than 16% but less than 30% I must make an election to access common law and this must be made within the time specified in the Workers' Compensation and Rehabilitation Act 1981 (which in most cases is six months after the commencement of weekly compensation payments) however, this requirement does not apply if I have a disability of 30% or more.

Dated this …….. day of …….. Year ……..

Signature of worker …….. 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 …….. day of …….. Year ……..

Signature of worker …….. 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 worker's compensation claim, including determining liability and whether my claim is true. This consent extends to my employers' 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 require dor permitted by Law. I also consent to my employers' insurer disclosing my personal details to the WorkCover WA which is authorised to use this information to fulfil it's functions and obligations under the Workers' Compensation and Rehabilitation Act 1981.

I have read the Privacy and Your Information Section and I consent to the Insurer dealing with my personal information in that manner.

Signed: …….. Date: ……..

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

**WORKERS' COMPENSATION CLAIM FORM 2B (REG 6AA)**
**SECTION 84(1)(b) OF THE WORKERS' COMPENSATION AND REHABILITATION ACT 1981**

# Employer Please Note

- 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;
- You must 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*

**ATTN: 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 THE INJURED 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/rehabilitation program for injured workers: □ YES □ NO

| Injured worker's pre-accident duties: | Possible alternative duties: |
|---|---|
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |

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

**Please complete all sections of this form**