

The Application for Compensation Form is an approved form under the Workers' Compensation and Rehabilitation Act 2003. The information contained on this and the following page is not part of the approved form.

This 'Important Information' is provided to assist you in completing this form and to give you an understanding of your rights and obligations under the Workers' Compensation and Rehabilitation Act 2003.

References to relevant sections of the Workers' Compensation and Rehabilitation Act 2003 are included in the following information.

PLEASE READ THIS IMPORTANT INFORMATION

Who completes the Application for Compensation Form?

The injured worker must complete the Application for Compensation Form if they wish to apply for workers' compensation benefits. If you are the injured worker and for some reason you are unable to complete the application form, another person may do so on your behalf.

Act reference: section 132.(5)

Completing the Application for Compensation Form

The entire form must be completed. Please complete all questions as accurately as possible. If a question does not apply to your situation, please write "n/a" or "not applicable" in the relevant area.

Space is provided before the end of the form if you have any additional information, diagrams, etc., you would like to include on the form. If there is insufficient space on the form to adequately answer any question, please attach any additional pages of information to the form.

If you need assistance in completing the form please contact your site's Rehabilitation and Return To Work Coordinator or telephone your employer's workers' compensation insurer. The phone number is on the back of this form.

What documents are needed to assess a claim?

The insurer needs the following documents to start assessing a claim:

- A completed **Application for Compensation Form**; and
- An original **Workers' Compensation Medical Certificate***, signed by the registered doctor or dentist who treated your injury, or a Declaration if you have not seen a doctor, must accompany the application form.

Act references: sections 132.(1), 132.(3)(a) and 132.(4)

How are claims assessed?

The insurer assesses each claim on its merits. Although the majority of claims are determined in a timely manner, there may be occasions where the insurer needs additional information, such as a statement from the injured worker about the circumstances surrounding their injury, or the opinion of an independent medical specialist.

Act references: sections 132.(3)(b) and 135.(1)

Your entitlement to compensation

Benefits are paid from the day your entitlement arises, which is usually the day your injury is assessed by a registered doctor or dentist. However, if your injury is assessed on the same day you are injured, weekly compensation is paid from the day after you are injured.

Act reference: section 141.(1)

If your application form is lodged more than **20 business days** after the date of entitlement, benefits may be paid only from 28 days before the day on which you lodged your application form.

Act reference: section 131.(2)

Your application form is valid and enforceable only if lodged within **6 months** of the date of entitlement.

Act reference: section 131.(1)

What benefits are paid?

If a claim is accepted, your employer's workers' compensation insurer pays compensation such as periodic payments as income replacement and also medical, hospital and rehabilitation costs. Regardless of the outcome of a claim, employers must pay their employee's wages for the day the injury happened.

Getting back to work early and safely

Rehabilitation is the key to getting injured workers back to work early and safely, through the ongoing coordinated use of medical, social, educational and vocational measures.

Both workers and their employer must take active roles in rehabilitation. For help getting started on rehabilitation, talk to your treating doctor and your site's Rehabilitation and Return To Work Coordinator, or telephone your employer's workers' compensation insurer.

It is a requirement that you satisfactorily participate in rehabilitation. If you fail to do so or refuse to participate without reasonable excuse, the insurer may suspend your entitlement to compensation.

Act references: sections 228 and 232



What does "engage in a calling" refer to?

If you engage in a calling or return to work of any kind or in any capacity you must notify your employer's workers' compensation insurer in writing within 10 business days. The notice you give may be in the form of a **Workers' Compensation Medical Certificate***, signed by a registered doctor or dentist and stating your capacity for work.

Act reference: section 136

A "calling" means any activity which usually results in a payment of wages, salary, or reward. It includes self-employment or working in an occupation, trade, profession or carrying on a business, whether for financial or other benefit.

Act reference: schedule 6

Fraud or false or misleading information

There are severe penalties for fraud, or where there is any attempt to defraud your employer's workers' compensation insurer, or where false or misleading information is provided. Providing false or misleading information in relation to your compensation application would be an example of this.

Your privacy

Your employer's workers' compensation insurer may give relevant information about your claim to another person. Some examples of such a person would be: your treating doctor, an allied health professional, a rehabilitation professional or an independent medical specialist.

The insurer will only give out relevant information when it is necessary to assist with the following: the determination or management of your claim, your or another persons' statutory rights, or where it is otherwise required by legislation.

Right of review of decisions

You have a right to have certain decisions reviewed by Q-COMP.

Act reference: section 540

The decisions to which the right of review applies include, but are not limited to:

- a decision to reject a compensation application;
- a decision to suspend a worker's compensation entitlement because that worker failed to participate in rehabilitation as required; or
- a decision to otherwise terminate, suspend, increase or decrease the amount of weekly compensation.

Act reference: chapter 13, part 2

Right to appeal review decisions

You have a right to appeal a review decision to the Queensland Industrial Relations Commission and thereafter to appeal the Queensland Industrial Relations Commission's decision to the Industrial Court. Your employer has the same appeal rights that you have.

Act reference: sections 549 and 561

The review decisions to which the right to appeal applies include, but are not limited to:

- a review decision about an insurer's decision to reject a compensation application; or
- a review decision about an insurer's decision about payment of compensation.

Act reference: chapter 13, part 3

How to lodge your Application for Compensation Form

To lodge your **Application for Compensation Form**, please have your site's Rehabilitation and Return To Work Coordinator send your completed form and Medical Certificate to your employer's workers' compensation insurer, or send the documents directly to the insurer yourself.

The address and contact details for the insurer are provided on the last page of the **Application for Compensation Form**.

Application for Compensation Form pursuant to section 132 of the Workers' Compensation and Rehabilitation Act 2003

This Application for Compensation Form is an approved form under the Workers' Compensation and Rehabilitation Act 2003.

The entire form must be completed. Please complete all questions as accurately as possible. If a question does not apply to your situation, please write "not applicable" or "n/a" in the relevant area.

This and the following three pages comprise the approved form.

PLEASE COMPLETE THIS APPLICATION IN BLOCK LETTERS AND TICK BOXES WHERE APPLICABLE

CLAIMANT'S DETAILS

1. Employee/Payroll Number:

2. Surname or family name:

3. Given or first names:

4. Title: Mr Mrs Ms Miss

5. Date of birth: / /

6. Gender: Male Female

7. Former name: (if applicable)

8. When was this former name used?

9. Reason for change?
(e.g. marriage etc.)

10. Do you require an interpreter?
 Yes (see below) No

IN WHICH LANGUAGE?

11. Principal place of residence:

STREET
 SUBURB/TOWN POSTCODE

12. Do you have a different postal address?
 Yes (see below) No

STREET
 SUBURB/TOWN POSTCODE

13. Contact Details:
 HOME WORK
 MOBILE
 EMAIL

EMPLOYER'S DETAILS

14. Full name of employer/site:

15. Business address:

STREET
 SUBURB/TOWN POSTCODE

16. Which department are you in?

17. Who was the supervisor on shift when you were injured?

18. If the injury occurred over a period of time; who was the supervisor when you reported your injury?

EMPLOYMENT DETAILS

19. What is your job title?

20. Which crew are you in and what roster do you follow?

21. How long have you worked in your occupation?
 YEARS MONTHS

22. How long have you been employed by this employer?
 YEARS MONTHS

23. Are you employed or self-employed or derive income in any other job than the one in which you were injured?
 Yes (see below) No

DETAILS

24. Do you receive any Centrelink or insurance benefits?
 Yes (see below) No

DETAILS

INJURY DETAILS

25. What is the nature of your injury?
(e.g. cut, strain, fracture, etc.)

26. Which part of your body is injured?
(e.g. right index finger, lower back, etc.)

41. Please provide the names of all treatment providers seen for this condition:
(e.g. nurse, physiotherapist, chiropractor, ambulance officer, masseuse, GP or specialist etc.)

WITNESS DETAILS

42. Name, address and telephone number of each witness:
(A witness is anyone able to give information about the event - they do not necessarily have to be an eyewitness to the event.)

MOTOR VEHICLE DETAILS

43. Details of any motor vehicle/s involved in the incident:
(registration numbers, owners of vehicles and their insurers)

44.

ADDITIONAL INFORMATION

(Space provided for additional information, diagrams, etc.)

PLEASE READ AND COMPLETE THE "CLAIMANT'S STATEMENT" ON THE NEXT PAGE



CLAIMANT'S STATEMENT

In completing this Application for Compensation Form, I acknowledge that I have read and understood the Important Information at the beginning of this form (the introductory two pages) about this form. I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading.

I hereby authorise any doctor, health authority, allied health provider, rehabilitation provider or other insurer to disclose to my employer's workers' compensation insurer any information regarding my medical history relevant to this claim.

I agree to advise my employer's workers' compensation insurer if there is any change in my circumstances or if I become aware of any matter that would make the above information false or misleading. In particular, I will advise my employer's workers' compensation insurer upon the occurrence of any change in my employment status during the currency of my claim.

The information contained in this Application for Compensation Form is true and not misleading.

Signature of Claimant

Print Name:

Date:

I declare that the Claimant has confirmed to me that they have understood the information about and in this form, and, has completed the form to the best of their knowledge.

Signature of Person who Witnessed Claimant's Signature

Print Name:

Date:

YOUR SITE'S REHABILITATION AND RETURN TO WORK COORDINATOR CAN SEND YOUR COMPLETED APPLICATION FORM AND MEDICAL CERTIFICATE TO YOUR EMPLOYER'S WORKERS' COMPENSATION INSURER, OR YOU CAN SEND THE DOCUMENTS DIRECTLY TO THE POSTAL ADDRESS LISTED OPPOSITE

BHP BILLITON
QUEENSLAND WORKERS' COMPENSATION

OFFICE ADDRESS AND ADDRESS FOR SERVICE:

Level 23, 71 Eagle St,
Brisbane QLD 4000

POSTAL ADDRESS

GPO Box 845
Brisbane Queensland 4001

TELEPHONE:

Toll Free 1800 247 927

FACSIMILE:

(07) 3329 2605