WOOLWORTHS GROUP

# APPLICATION FOR COMPENSATION FORM FOR WORKERS

# PLEASE READ THIS IMPORTANT INFORMATION

This Application for Compensation Form for Workers is an approved form under the *Workers Compensation and Rehabilitation Act* 2003.
The "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.
Relevant sections of the *Workers' Compensation and Rehabilitation Act* 2003 are included in the following Information. You can obtain the Application for Compensation Form for Workers from your Rehabilitation Coordinator or from EML Self Insurance, Level 4, 127 Creek Street, Brisbane. You can also obtain the form off the Woolworths Group Safety & Health intranet site: https://sites.google.com/a/woolworths.com.au/safety/homepage/workers-comp/claim-forms

## Who completes the Application for Compensation Form for Workers?

The injured worker must complete the Application for Compensation Form for Workers.
If you are the injured worker and for some reason are unable to complete the form, another person may do so on your behalf (see section 132(5) of the Act).

## Procedure for completing the Application for Compensation Form for Workers

If you require assistance in completing the form, please contact EML Self Insurance, Claims Agent for Woolworths Group Workers Compensation Self insurance Scheme on (07) 3014 1353 or (07) 3014 1365.

You are required to complete all details in **SECTION A**. However, if any question is not applicable to your situation, please make it "n/a" or "not applicable".
If there is insufficient space on this form to adequately answer questions, please attach additional pages.

## What does the insurer need to assess a claim?

The insurer needs the following documents to start assessing a claim:
**- A completed Application for Compensation Form for Workers.**
**- An original Workers' Compensation Work Capacity Certificate signed by the doctor or by a registered dentist who attended you, must accompany this application form (see sections 132(3)(a) and (4) of the Act).**

## How do you lodge your claim?

The application form and supporting documents are to be lodged with Self Insurance, Employers Mutual via email: selfinsurance@eml.com.au

**DO NOT LODGE ANY DOCUMENTS WITH WORKCOVER QUEENSLAND**

## 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 workers' compensation insurer may require additional information.
Where a determination cannot be made within 20 business days, EML acting for Woolworths Group Limited will advise you of the non-determination, your right to review and the activities required for determination.

## Your entitlement to compensation

Your entitlement to compensation arises on the date your injury is assessed by a doctor or dentist (see section 141(1) of the Act). Your application for compensation is valid and enforceable only if it is lodged within 6 months after the entitlement to compensation arises (see section 131(1) of the Act). If your application is lodged more than 20 business days after your entitlement arises, the insurer may only pay compensation from 20 business days before the day on which you lodged your application (see section 131(2) of the Act).

## What compensation is paid by the insurer?

If a claim is accepted, the insurer may pay compensation such as weekly payments as income replacement and also medical, hospital and rehabilitation costs.
Employers have to pay their workers' wages for the day the injury happened.

Rehabilitation is the key to getting injured workers back to work quickly and safely. The insurer requires both workers and employers to take active roles in rehabilitation. For help getting started on rehabilitation, talk to your treating doctor and contact your insurer.

It is a requirement under the *Workers' Compensation and Rehabilitation Act* 2003 (see section 232 of the Act) 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.
**The injured worker should advise their doctor that Woolworths has a return to work program, and request that the doctor complete a workers compensation medical certificate.**
It may be necessary for the Rehabilitation/ Return to Work Coordinator to obtain information regarding worker's compensation from a doctor and/or another authority to assist with a rehabilitation program. The injured worker is asked to sign an authority which will allow the relevant information to be obtained.

## Engage in a "calling"

A "calling" means any activity which usually results in the payment of wages, salary or reward. It includes self-employment or working at an occupation, trade, profession or carrying on a business, whether or not you receive wages, salary or other reward (see Schedule 6 of the Act).
You must notify the insurer in writing within 10 business days if you return to work of any kind or in any capacity (see section 136 of the Act). You may do this by tendering a work capacity certificate which states that you are "fit to return to work".

## False or misleading information or fraud

There are severe penalties for fraud or where there is any attempt to defraud the insurer, for example, where false or misleading information is provided in an Application for Compensation Form for Workers or where a worker returns to work and does not notify the insurer in writing.

## Right of review of decisions

You have a right to have certain decisions reviewed by the Regulator (see section 540 of the Act). The decisions include a right of review of a decision by the insurer to reject an application for compensation or a decision to suspend your entitlement to compensation because you failed to participate in rehabilitation as required, or otherwise to terminate, suspend, increase or decrease a weekly payment of compensation (see Chapter 13 Part 2 of the Act).

## Right of Appeal

You have a right to appeal a review decision, for example, a decision about payment of compensation or decision made by the insurer or the Regulator (see Chapter 13 Part 3 of the Act). The appeal would be made to the Queensland Industrial Relations Commission.

## Your Privacy

Woolworths Group Limited, as the self insurer, is collecting your personal information in accordance with the *Workers Compensation and Rehabilitation Act* 2003 in order to assess your entitlement to compensation. Some of this information may be given to the Office of Industrial Relations - Workers Compensation Regulator for the purpose of fulfilling their requirements as the Regulator, and service providers for the purpose of conducting medical assessments or providing reports or other services to the self-insurer. Your information will not be given to any other person unless you have given your consent, or we are authorised or required by law.

**APPLICATION FOR COMPENSATION FORM FOR WORKERS**

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

**SECTION A – To be completed by WORKER**

PLEASE READ THIS IMPORTANT INFORMATION

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

You must complete the entire form. However, if any question is not applicable to your situation, please mark it "n/a" or "not applicable".

**1. Preferred title** ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr OTH ☐

**2. Surname or family name**

**3. Former surname or family name (*if applicable)***

**4. Given or first names**

**5. Gender** **Male** ☐ **Female** ☐

**6. Date of Birth**

**7. Do you require an Interpreter?** **Yes** ☐ **No** ☐

**8. Present residential address**

| |
|---|
| **NO** |
| **STREET** |
| **SUBURB/TOWN** |
| |
| **POSTCODE** **TELEPHONE** |

**9. Postal address (Postal Service if applicable)**
*(if the same as residential address, write "as above")*

| |
|---|
| **NO** |
| **STREET** |
| **SUBURB/TOWN** |
| |
| **POSTCODE** **TELEPHONE** |

**10. Telephone Number**

| |
|---|
| **WORK** |
| **HOME** |
| **MOBILE** |

**11. Email Address**

**12. More than one employer**

Please indicate if you were one or more of the following at the time of your injury, and, if so, state the name of organisation / employer

- ☐ A contractor
- ☐ A director of a corporation
- ☐ A member of a partnership
- ☐ A trustee
- ☐ A volunteer
- ☐ A self-employed individual
- ☐ Employed or self-employed in any job other than the one in which you were injured.

**13. At the time of injury were you either:**

**(A) Working temporarily in Queensland**

Yes ☐ No ☐

(please provide details)

**(B) Working for an interstate/overseas employer**

Yes ☐ No ☐

(please provide details)

**14. Do you receive a benefit from Centrelink / other benefit?**

Yes ☐ No ☐

(please provide details)

**15. Worker's bank details - We pay claim and medical reimbursement payments through electronic funds transfer**

**Name of bank:** _____

**BSB number:** _____

**Account number:** _____

**Account name:** _____

## Employer's Details

**15. Employer's name** (e.g. Woolworths Supermarkets)

| |
|---|
| **BUSINESS NAME** |
| **NO** |
| **STREET** |

| SUBURB/TOWN | POSTCODE |
|---|---|
| TELEPHONE | |

## Employment Details

**16. What is your occupation? (Please be specific)**

**17. How long have you been employed with your employer?**

| Years | Months |
|---|---|

**18. At the time of your injury, what was the basis of your employment?** I.e. Regular hours, part-time, full-time, casual employment, number of hours per week etc to determine whether "worker".

## Injury Details

**19. What is the nature of your injury?** (E.g. cut, strain, fracture, etc)

**20. What part of your body is injured?**
(E.g. right index finger, lower back, etc)

**21. Where was your injury sustained?**
(E.g. workshop floor, Smith Street, Bulimba)

| PLACE |
|---|
| STREET |
| SUBURB/TOWN |
| POSTCODE |

**22. When did your injury occur?**

| DAY | TIME | *am/pm* | DATE | / | / |
|---|---|---|---|---|---|

(*If the injury occurred over a period of time put O.P.T)*

**23. Did the injury happen:**

Before work ☐ Recess ☐

After work ☐ Over a period of time ☐

During the course of your ordinary work hours ☐ Unknown ☐

**24. If over a period of time, when did you first notice symptoms?**

**25. How was the injury sustained?**

**26. Activity at time injury was sustained**

**Questions 27 - 30 relate to journey claims only**

**27. If a journey claim -**
**If the injury occurred on your way to or from work, please state your starting time** (if on way to work) **or finishing time** (if on way home from work) **for work that day.**

| TIME am/pm |
|---|

**28. Was a motor vehicle/s involved?**
Yes ☐ No ☐

| *(Details of registration number/s, owners of vehicle/s)* |
|---|
| |
| |
| |

**29. Did the police or ambulance attend the accident?**
**(***if yes, please supply details of the officer and branch)*

**30. Names, addresses and telephone details of any witnesses.**

| NAME: |
|---|
| ADDRESS: |
| TELEPHONE: |
| NAME: |
| ADDRESS: |
| TELEPHONE: |

**31. Was the injury reported to your employer or your employer's representative?**
Yes ☐ No ☐

| NAME: |
|---|
| POSITION: |
| TELEPHONE: |

**32. When was the injury reported?**

**33. Did you stop work because of this injury?**

Yes ☐ No ☐

| DAY | TIME | *am/pm* | DATE / / |
|---|---|---|---|

**34. Did you receive medical treatment in hospital?**

Yes ☐ No ☐

| HOSPITAL NAME: | Public / Private |
|---|---|

**35. Have you returned to work?**

Yes ☐ No ☐

| DAY | TIME | *am/pm* | DATE / / |
|---|---|---|---|

**36. In what capacity** (e.g. Full time, Part time, Suitable Duties)

**37. Have you previously suffered any similar injuries or conditions?**

Yes ☐ No ☐

| DETAILS |
|---|
| |

**38. Have you previously claimed worker's compensation in Queensland for any similar injury or condition?**

Yes ☐ No ☐

| *DETAILS (including employer name & date of injury)* |
|---|
| |
| |
| |

**39. Have you claimed worker's compensation outside Queensland for a similar injury or condition?**

Yes ☐ No ☐

| *DETAILS (including employer name & date of injury)* |
|---|
| |
| |
| |

*Woolworths Limited, as the self insurer, is collecting your personal information in accordance with the Workers Compensation and Rehabilitation Act 2003 in order to assess your entitlement to compensation. Some of this information may be given to the Office of Industrial Relations for the purpose of fulfilling their requirements as the workers compensation regulator, and service providers for the purpose of conducting medical assessments or providing reports or other services to the self insurer. Your information will not be given to any other person unless you have given your consent, or we are authorised or required by law.

## Claimant's Statement

This form must be signed by the claimant unless he/she is unable to complete it. In these cases, it must be completed and signed by an agent of the claimant.

I acknowledge that it is an offence against the Worker's Compensation and Rehabilitation Act 2003 to make a statement that is false or misleading. The information I have provided is true and not misleading.

I acknowledge that I am obliged to satisfactorily participate in reasonable rehabilitation if required, unless I have a reasonable reason to not.

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

I agree to advise my worker's 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. I will advise my worker's compensation insurer if I undertake any employment (paid or unpaid), including self employment, during my claim.

**Claimant's Signature**:_____ **Date**:_____

**Agent of Claimant**:_____ **Date**:_____

**Agent's surname/family name**:_____

**Agent's given name**:_____

**Agent's address**:_____

**Reason claimant unable to sign**:_____

**What happens next?**

Employers Mutual manages all claims on behalf of Woolworths Group Limited, the self-insurer. Employers Mutual will confirm your claim number by phone or mail within 48 hours of claim registration.

Where a determination cannot be made within 20 business days, Employers Mutual acting for Woolworths Group Limited will advise you of the non-determination, your right to review and the activities required for determination.

If the claim is accepted, it will be managed by one of our Employers Mutual Case Managers in conjunction with the Return to Work Coordinator to assist with your recovery and return to work.

You are required to ensure you have a current Work Capacity Certificate – Workers' Compensation for the duration of your claim.

This form was approved by the Queensland Workers' Compenation Regulator on 15 November 2018, pursuant to section 586 of the *Worker's Compensation and Rehabilitation Act* 2003. Version 3.