Claim for Workers Compensation

About this Form

This form is to be completed if you wish to claim workers compensation under the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act). *Part One* is for you to complete. *Part Two* is for your People Leader to complete.

Once the questions in both parts have been answered; your People Leader will lodge the form with the Employee Health Management Team at Medibank Private, along with any supporting documentation you have provided.

If you need assistance to complete this form; please contact your People Leader or the Employee Health Management Team at Medibank Private (employeehealthmanagement@medibank.com.au).

Rehabilitation and Return to Work

Medibank Private will assist all injured employees to achieve an early and safe return to work, including pre-injury duties where possible. You may need to undergo an assessment for rehabilitation. If a rehabilitation program is developed to assist your return to work; you must undertake the program as set out in the written return to work schedule.

For more information about rehabilitation visit www.comcare.gov.au or the Medibank Injury and Illness Management Intranet page.

Privacy Statement

Medibank Private is committed to the protection of your privacy and has systems that incorporate privacy and confidentiality requirements in compliance with the Privacy Act 1988 (Cth). We are committed to ensuring that personal information collected, used, stored or disclosed is accurate, up-to-date and complete.

Medibank Private and the other parties listed below need to collect personal information about you in order to determine your entitlement to compensation and to perform other functions required by the SRC Act.

The personal information collected on this form and during the course of the management of your claim is protected by the *Privacy Act 1988* and will be used only for compensation, rehabilitation and workplace health and safety purposes.

You have the right to refuse to provide, or allow the collection of, your personal information if you so choose. However, if you choose to refuse to allow us to collect this information, we may be unable to determine your claim and you would then not have any access to ongoing vocational rehabilitation under the SRC Act.

Medibank Private may need to disclose your personal information to third parties such as:

- Comcare
- The Safety, Rehabilitation and Compensation Commission
- Medibank and its subsidiaries to the extent necessary for the management of your claim.
- Medibank's Third Party Claims Administrator
- Medibank Private's IT Service Provider
- Your People Leader
- Any future employer
- Your superannuation fund manager or trustee

- Medical practitioners and other health professionals
- Rehabilitation service providers and Case Managers
- Vocational and functional assessors
- Employment agencies
- Loss adjusters and other private investigators
- Work health and safety investigators
- Legal advisers and law enforcement authorities
- Persons engaged by Comcare to conduct research related activities
- Auditors engaged by Medibank Private and Comcare
- Any other person assisting Medibank Private and Comcare in the performance of their functions or exercise of their powers
- Other government entities where there are obligations under law to do so.

Medibank, Comcare and other parties included in the above list are not likely to disclose personal information to any party outside of Australia, unless the information relates to an incident, investigation, injury or illness sustained while overseas, or treatment provided by an overseas practitioner. If disclosure of personal information is made to an overseas recipient, we will comply with obligations regarding disclosure to overseas entities (Australian Privacy Principle 8).

Medibank Private's Privacy Policy contains more information about our privacy practices, including how you may request access to, or correction of, personal information we hold about you, how you can lodge a privacy complaint and how we manage such complaints. You can obtain a copy of our Privacy Policy on the Medibank intranet page.

MEDIBANK'S THIRD PARTY CLAIMS ADMINISTRATOR

EML Solutions (EML) is Medibank's Third Party Claims Administrator, responsible for managing individual claims in consultation with Medibank.

EML's details are as follows:

EML - Medibank Private Limited, Self Insurance Claims
GPO Box 805
Canberra ACT 2601

Phone number: 1800 571 925

E-mail: medibankselfinsurance@eml.com.au

PRIVACY NOTE: EML is committed to the protection of your privacy in compliance with the *Privacy Act 1988* (Cth). EML's Privacy Policy provides further information about its privacy practices and can be https://www.eml.com.au/privacy.

PART ONE – EMPLOYEE TO COMPLETE

Please note that you should submit, along with this form, a medical certificate from a legally qualified medical practitioner that includes:

- **a clear medical diagnosis of your injury or illness,**
- **an opinion on its cause, and**
- **full details of any incapacity for work or employment restrictions.**

WORKER'S PERSONAL DETAILS

What is your full name?	Title: Mr ☐ Mrs ☐ Ms ☐ Other ☐ …… Surname: Given name(s):
Do you have, or have you ever had, any other name(s)?	No ☐ Yes ☐ What name(s)?
Gender	Male ☐ Female ☐ Non-Binary ☐
Date of Birth	
How can we contact you during the day?	Home telephone number: Work telephone number: Mobile phone number: Email address: We want to ensure we are contacting you in a way that works best for you. Please let us know if you prefer any of the below options: Email ☐ Phone ☐
Do you need an interpreter?	No ☐ Yes ☐ What language?
Residential Street Address	Residential Street Address Suburb State

	Postcode
Do you have a different postal address?	No ☐ Yes ☐. Please give details:
Do you need another person to act on your behalf for this claim (e.g. a partner, support person or solicitor)	No ☐ Yes ☐ Please give details: Name: Daytime telephone no.: Postal Address:

EFT DETAILS

If your claim is accepted and we need to reimburse you the cost of medical treatment (or if we need to pay incapacity benefits), we require your bank account details to arrange payment.

Bank:		Account No:	
BSB No:		Account Name:	

EMPLOYMENT DETAILS

What is your usual occupation?	Full time ☐ / Part time ☐ ?
What is the full address of your usual workplace?	
Did you have any other employment at the time you were injured?	No ☐ Yes ☐ Please give details:
Job Title	
Department	
People Leader	Name: _____ Tel: _____

INCIDENT AND WORKER'S INJURY DETAILS

What was the date and time the injury/condition occurred?	Date: Time:	When did you first notice the injury/condition?	Date: Time:
Where were you when the injury occurred or you noticed the injury/condition? [include both the full address, as well as your actual physical location, if at work]			
What were you doing when the injury occurred or you noticed the injury/condition?	At work performing normal duties ☐ At work, for the purposes of your employment, during an ordinary recess ☐ Away from your normal workplace undertaking an activity associated with your employment or at the direction of your employer ☐ [please provide details]: Travelling at the direction or request of your employer, for the purposes of your employment ☐ [please provide details]: Other ☐ [please provide full details]:		
What task/s were you doing when you were injured?			
When and where did you first seek medical treatment for your injury or illness?	Date: Time:	If you stopped work, what was the date and time?	Date: Time:
Previous treatment provider:	Name: Telephone No:	Address:	
What type of duties are you currently performing?	Normal duties ☐ Suitable duties ☐ No duties ☐		

What is your injury / condition and which parts of your body are affected?	Condition: Part(s) of body injured:
What happened and how were you injured?	
Have you previously had another injury/condition affecting this part of the body? (use additional sheet if required)	No ☐ Yes ☐ If Yes, please provide details
Have you ever claimed workers compensation for a similar injury or illness? (Please answer this question even if the claim was not accepted).	No ☐ Yes ☐ If Yes, please give details: Year claimed: Claim No: Employer at time of injury:
Was there a witness to your injury? Please note that witnesses may be asked to provide a statement in some cases. Please attach a witness statement if you feel that it would assist in determining liability for your claim.	No ☐ Yes ☐ If Yes, please give details: Name of witness Telephone number
Were you under the influence of alcohol or a drug (including prescription medication) at the time of your injury?	No ☐ Yes ☐ If Yes, please give details of any prescription medication taken or the alcohol consumed or drugs used.

AUTHORISATION AND DECLARATION

Please read and sign this authorisation and declaration.

1. I authorise and consent to:
   i. Medibank Private collecting my personal information from, using it, and disclosing my personal information to any of the parties listed in the 'Privacy statement' on page 1 of the claim form.
   ii. any of the above parties collecting my personal information from, and disclosing my personal information to, Medibank Private or each other;
   iii. a photocopy of this Authority being sufficient evidence of my authority and consent to collect or disclose my personal information.
2. I acknowledge and understand this consent includes collecting, using or disclosing information in relation to my compensable and any non-compensable conditions.
3. I acknowledge and understand that if I refuse to give my consent, or if I restrict my consent, or if I withdraw my consent to collect, use or disclose my personal information, and Medibank Private or its Third Party Claims Administrator believes:
   i. that I have information relevant to my claim; or
   ii. that I can obtain information relevant to my claim without unreasonable expense or inconvenience,

   Medibank Private can issue me a written notice requesting me to give the information to it.
4. I acknowledge and understand that if I refuse or fail, without reasonable excuse, to comply with such a written notice, Medibank Private may refuse to deal with my claim until I provide the information or copy of a document referred to in the notice.
5. I am aware that I must advise Medibank Private immediately if I engage in any employment, whether paid or not, or in the running of a business in my own right or as a partner during the period I am absent from work as a result of this injury/disease.
6. I am aware that I must advise Medibank Private if my injury or disease improves during any period of incapacity sufficiently to allow me to return to work;
7. I am aware that giving false or misleading information in support of this claim is a serious offence which is punishable by law under the Criminal Code Act 1995.
8. I am aware that any monies paid by Medibank Private as a result of a false or misleading statement or claim will be recovered.
9. I acknowledge that I have read and understand the "Privacy Statement" notice.
10. If someone has assisted me to complete this form, I acknowledge that they have explained the above notices to me and I understand my obligations.

Print your name: _____

Telephone number: _____

Your signature: _____

Date: _____

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For Better Health

PART TWO – PEOPLE LEADER TO COMPLETE

When did the employee first notify you of the injury / incident?	Date: Time:
What did the employee report to you?	
On what date did you receive this form from the employee?	
What type of duties is the employee currently performing?	Normal duties ☐. Suitable duties ☐ No duties ☐ If suitable duties; what do these duties entail?
Has the employee taken any time off work as a result of the injury / incident?	No ☐ Yes ☐ If Yes, please give details
Are you aware of any physical, psychosocial or workplace barriers that may delay the employee's timely return to work?	No ☐ Yes ☐ If Yes, please give details
Do you have any further information you would like to provide in relation to this claim? (use additional sheet if required)	

Print your name: _____

Telephone number: _____

Your signature: _____

Date: _____