WorkSafe VICTORIA

VICTORIAN WORKCOVER AUTHORITY

CLAIM FOR COMPENSATION FOLLOWING A WORK-RELATED DEATH

This form is to claim for compensation following the work-related death of a worker under Victorian workers compensation legislation. A person claiming compensation or someone on their behalf (e.g. parent, guardian) may complete this form.

FOR HELP COMPLETING THIS FORM OR FOR MORE INFORMATION CONTACT:

- The worker's employer.
- The employer's WorkSafe Agent - to find out who the Agent is call the WorkSafe Advisory Service: freecall 1800 136 089 or (03) 9641 1444.
- The worker's union.
- Union Assist – a free service set up and run by the Victorian Trades Hall Council: (03) 9639 6144.
- WorkSafe Advisory Service – the WorkSafe call centre: freecall 1800 136 089 or (03) 9641 1444.

TO MAKE A CLAIM YOU NEED TO:

✓ Carefully read this form including the statement on the back of this form that explains how personal and health information will be collected and used.

✓ Carefully complete this form preferably using a black ballpoint pen. You must answer all questions that apply to you on this form. The form may be returned to you if it is incomplete. If there is insufficient space to answer a question, please attach additional notes or information.

✓ Give or serve this claim form on the worker's employer within two years of the date of the worker's death (although this time limit can be extended if a special excuse for not making the claim is accepted by the WorkSafe Agent). If you have difficulty giving this claim to the employer or the employer refuses to take receipt of the claim form, you can send it directly to the WorkSafe Agent or WorkSafe if the Agent is not known.

✓ Report the worker's death to the police if the worker's death resulted from an accident involving a 'motor vehicle'. This is defined in the *Road Safety Act 1986* as a vehicle that is used or intended to be used on a highway and that is built to be propelled by a motor that forms part of the vehicle. This would include any car, truck, motorbike, bus, registered tractor, or a registered forklift etcetera. Trains, trams and motorised wheelchairs are excluded.

✓ Keep a copy of this form and any attachments for your records.

ENTITLEMENTS:

Entitlements are determined in accordance with Victorian workers compensation legislation and may include:

- Payment or reimbursement of the reasonable costs of medical and like services received by the worker because of the work-related injury/death.
- Burial or cremation costs (capped at a maximum amount).
- Family counselling (capped at a maximum amount per family).
- Lump sum payment and pension for family members who are 'dependants' (capped at a maximum amount). A 'dependant' family member is a partner of the worker, as well as any child (including a child born after the death of the worker) who was wholly, mainly or partly dependent on the earnings of the worker at the time of the worker's death or, would have been wholly, mainly or partly dependent on the earnings of the worker but for the worker's incapacity from their injury.
- Reimbursement of expenses incurred by 'non-dependent' family members as a result of the injured worker's death (capped at a maximum amount).
- Entitlements, including whether a person is a 'dependant' or 'non-dependent' family member, are determined by the WorkSafe Agent, except for claimants who are minors (children under 18 years), persons under a disability or not legally represented. Entitlements for these claimants are determined by the Magistrates' Court or County Court.

NOTE FOR EMPLOYERS:

- You must complete the section titled *For completion by the employer.*
- This claim form must be forwarded to your WorkSafe Agent within 10 days of receipt together with your completed *Employer Injury Claim Report.*

CLAIM FOR COMPENSATION FOLLOWING A WORK-RELATED DEATH

1. DECEASED WORKER'S PERSONAL DETAILS

Title | Family name

Given names

Other known or previous legal names *(e.g. maiden name)*

Date of birth / /

Gender ☐ Male ☐ Female

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

2. INJURY AND DEATH CIRCUMSTANCES

(Please refer to the front page about obtaining assistance with these questions)

Has a claim for compensation previously been made by the worker for the injury/condition causing or contributing to the worker's death? ☐ Yes ☐ No

If yes, please give details including claim number(s)

What was the injury/condition that caused or contributed to the worker's death and the body part/s affected *(e.g. crush injuries to upper body, broken leg)*?

Did the injury/condition causing or contributing to the worker's death occur on a particular date or over a period of time?

☐ Particular date and time (if known)

/ / am/pm

☐ Period of time months/years

and the injury/condition was first noticed on

/ /

Please attach a copy of the worker's full or interim death certificate

You can obtain a copy of the death certificate from Births, Deaths and Marriages Victoria or the equivalent State or Territory registry. If the death has not yet been registered and you do not yet have a copy of the death certificate at this time, please answer the following questions as best as possible:

What was the medical reason given for the cause of the worker's death *(e.g. ischemic heart disease)*?

What is the date and time (if known) of the worker's death?

/ / am/pm

FOR504/05/12.16

Where did the death occur?

Where did the injury/condition that caused or contributed to the worker's death occur? If applicable, please provide the street address of the workplace or work site and the exact location where the injury/condition occurred (e.g. boiler room) if known.

Did the injury/condition occur at the employer's workplace or work site? ☐ Yes ☐ No

If no, please provide details about which person or organisation was responsible for the workplace or work site if applicable or the street/address where the injury/condition occurred

Please provide as much detail as possible about what the worker was doing when the injury/condition that caused or contributed to the worker's death occurred

Please indicate which of the following circumstances applied when the injury/condition causing or contributing to the worker's death occurred:

- ☐ Worker was working at the usual workplace or work site
- ☐ Worker was working away from the workplace or work site
- ☐ During a meal-break or authorised recess at work
- ☐ Whilst worker was away from work during a recess
- ☐ Worker was travelling to or from work
- ☐ A motor vehicle accident while the worker was working.

If the injury causing or contributing to the worker's death was the result of driving or using a motor vehicle or the use of public transport:

What police station was the motor vehicle/public transport accident/incident reported to (if known):

Please provide details of the registration numbers and applicable State or Territory of registration of any motor vehicles involved if the accident/incident (if known):

Registration number and State/Territory registered

Registration number and State/Territory registered

Registration number and State/Territory registered

Do you believe a third party is in any way responsible for the injury/condition that caused or contributed to the worker's death (e.g. a manufacturer, supplier, contractor etc)? If yes, please give details including the reasons for your belief and name and address of third party (if known)

3. WORKER'S EMPLOYMENT DETAILS

Name of the person/organisation who paid the worker

Street address of the worker's employer
Number/Street/Suburb/State/Postcode

Name and daytime contact number of the employer contact
(if known)

What was the worker's usual occupation?

Which of the following applied to the worker:
(Please tick all relevant boxes)

☐ *full-time* ☐ *part-time* ☐ *casual* ☐ *student*
☐ *contract* ☐ *trainee* ☐ *apprentice* ☐ *volunteer*
☐ *permanent* ☐ *temporary* ☐ *agency worker* ☐ *contractor*
☐ *seasonal* ☐ *jockey*

Other

When did the worker start working for this employer?

/ /

Please indicate if any of the following applied to the worker:

☐ Yes ☐ No A director of the employer's organisation
☐ Yes ☐ No A partner in the employer's organisation
☐ Yes ☐ No A sole trader
☐ Yes ☐ No A relative of the employer

Did the worker have any other employment at the time of the injury/condition causing or contributing to the worker's death:

☐ Yes ☐ No

Please provide or attach information about the names of any other employers of the worker, their contract details and any relevant wage or payment records

4. WORKER'S PRIMARY EARNINGS DETAILS

Please complete this section if compensation is claimed on the basis of you or others being a dependant of the worker - see the front page of this form for further information. Please attach copies of recent payslips if available.

How many standard hours (not including overtime) did the worker usually work each week before the injury/condition which caused or contributed to the worker's death occurred?

hours

What were the deceased worker's usual working hours?
(e.g. Monday - Friday, 8.30 am to 5.00pm)

What was the worker's usual pre-tax hourly rate (not including overtime or shift allowances)?* $

What were the worker's pre-tax weekly earnings (not including overtime or shift allowances)?* $

Please provide details of any overtime or shift work worked by the worker:

Weekly shift allowance: $

Weekly overtime hours $

5. DEPENDANT AND GUARDIAN DETAILS

Please complete this section if compensation is claimed on the basis of you or others being a dependant of the worker- see the front page of this form for further information.

Please provide full details of all known dependants (including children not yet born) who are included in this claim. For each child under the age of 18 years, please provide details of each child's guardian (compensation can only be paid to the guardian for the child's benefit).

Please attach further information or details if space is insufficient.

DEPENDANT ONE

Title Family name

Given names

Other known or previous legal names *(e.g. maiden name)*

Date of birth / /

Gender ☐ Male ☐ Female

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

Relationship to the worker

Full-time student at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Full-time apprentice at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Guardian details *(if applicable for children under 18 years)*

Name

Residential street address

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

DEPENDANT TWO

Title Family name

Given names

Other known or previous legal names *(e.g. maiden name)*

Date of birth / /

Gender ☐ Male ☐ Female

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

Relationship to the worker

Full-time student at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Full-time apprentice at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Guardian details *(if applicable for children under 18 years)*

Name

Residential street address

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

DEPENDANT THREE

Title | Family name

Given names

Other known or previous legal names *(e.g. maiden name)*

Date of birth / / | Gender ☐ Male ☐ Female

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

Telephone number(s) | Relationship to the worker

Full-time student at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Full-time apprentice at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Guardian details *(if applicable for children under 18 years)*
Name

Residential street address

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

DEPENDANT FOUR

Title | Family name

Given names

Other known or previous legal names *(e.g. maiden name)*

Date of birth / / | Gender ☐ Male ☐ Female

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

Telephone number(s) | Relationship to the worker

Full-time student at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Full-time apprentice at the time of the worker's injury/condition causing death: ☐ Yes ☐ No

Guardian details *(if applicable for children under 18 years)*
Name

Residential street address

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

6. OTHER KNOWN DEPENDANTS

Are you aware of any other person who may also have been a dependant of the worker and who may be separately entitled to make a claim? ☐ Yes ☐ No

If yes, please provide details (if known)

Name(s)

Address

Telephone number(s)

Name(s)

Address

Telephone number(s)

Please attach further information or details if space is insufficient

7. DETAILS OF PERSON COMPLETING THIS CLAIM FORM

Title | Family name

Given names

Residential street address
Number/Street/Suburb/State/Postcode

Postal address *(if same as residential address write 'as above')*

Telephone number(s)

8. DECLARATION OF PERSON COMPLETING THIS CLAIM FORM

I have read the information provided in this form. I declare that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted.

Signature

Date / /

9. EMPLOYER LODGEMENT DETAILS

When did the employer first receive this claim form?
/ /

Employer's signature

Date / /

Name

Position

Employer's scheme registration number
(e.g. WorkCover Employer, Policy or Employer Registration Number)

CLAIM FOR COMPENSATION FOLLOWING A WORK-RELATED DEATH

COLLECTION OF PERSONAL AND HEALTH INFORMATION TO MANAGE YOUR CLAIM*

In processing your claim, the Victorian WorkCover Authority (WorkSafe) and any WorkSafe Agent acting for WorkSafe in relation to your claim may collect personal and health information about the deceased worker and dependants. WorkSafe and its Agents are required by law to ensure that all people about whom they collect personal and health information are provided with the following information:

WorkSafe is a body corporate established under Victorian workers compensation legislation. Agents are appointed by WorkSafe under the legislation to act on its behalf in managing workers compensation policies and claims for compensation.

Personal and health information is collected on this form and may also be collected during the processing, assessing and management of your claim. It may be collected from current and previous employers of the worker, the claimant and other government agencies, credit reporting agencies, health service providers and other persons who can provide information relevant to the claim.

Personal and health information may also be collected by lawyers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the employer's Agent. Personal and health information collected about the deceased worker is used for the purpose of processing, assessing and managing your claim and to verify any evidence you may submit in support of the claim. The information may also be used for one or more of the purposes listed in Victorian workers compensation legislation, for the purposes of legal proceedings arising under the legislation, and to assist WorkSafe and Agents to better manage claims generally.

For the purpose of processing, assessing and managing your claim, WorkSafe and the worker's employer's Agent may disclose personal and health information about the worker and the claimants to each other and to the following types of organisations:

- employees, contractors and agents of WorkSafe and Agents
- the deceased worker's employers
- lawyers, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the Agent in relation to the claim
- the Accident Compensation Conciliation Service and Medical Panels
- a court or tribunal in the course of criminal proceedings or any proceedings under any of the Acts which WorkSafe administers

any other person, organisation or government agency authorised by you, or by law, to obtain information.

Collection of this information may be required by the Victorian workers compensation legislation. If you do not provide any part or all of this information, your claim may not be accepted or processed. You may request access to personal and health information about the deceased worker collected by WorkSafe or the employer's Agent by contacting the deceased workers employer's Agent.

WorkSafe's policies for managing personal and health information are set out in its Privacy Policy, which is available from your nearest WorkSafe office or at the WorkSafe website at: **worksafe.vic.gov.au**. Information relating to your right to access your WorkSafe claim information is also available at the website.

[*If the deceased worker's employer is an approved self-insurer, references to 'WorkSafe' and 'Agent' should be read as if they were references to 'self-insurer' and 'approved agent of a self-insurer'.]