



Coal Mines Insurance

## Worker's Injury Claim Form Industrial Deafness

Should you require any assistance, including the services of an interpreter to complete this form, please contact CMI on 1800 WORKER (1800 967 537)

### 1. Personal details

Title	Surname	Given name(s)	Other/previous legal names
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	Gender		
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>		
Home address	State		
<input type="text"/>	<input type="text"/>		
	Postcode		
<input type="text"/>	<input type="text"/>		
Postal address (if different from above)	State		
<input type="text"/>	<input type="text"/>		
	Postcode		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Home phone number	Mobile phone number	Email address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

### 2. Employment details

Are you currently employed and working in the NSW coal mining industry?

Yes ☐ No ☐ ► Date last worked:

#### Employment history

Please provide details of your work history over the last five (5) years prior to making this claim (and earlier, if possible). You must include any work as an employee, in self-employment, partnership, military service or otherwise. Even if you are unsure whether the work was noisy, please include these details.

Employer Name and location	Job title	Description of your work duties Type of tasks, frequency over average day or week, machines and equipment	Period YYYY - YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

\*If you require further space, please attach a separate letter with these details

### 3. Other details

Have you been exposed to noisy environments outside of your employment? E.g. shooting, loud music.

Yes ☐ ► Please provide details below

No ☐ ► Go to Section 4

Activity	Description of activity and exposure to noise	Period
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 4. Previous claims

Have you made any claims for hearing loss previously?

Yes ☐ No ☐ ► Go to Section 5

If yes, who was the claim with (name of employer and insurer) and what was the outcome?

## 5. Privacy notice

CMI will collect your personal information (including sensitive information and health information) for the purpose of processing, assessing and managing your workers' compensation claim (Claim), including determining liability and whether your Claim is true. CMI is authorised to collect your personal information under the *Workplace Injury Management and Workers Compensation Act 1998* (NSW).

CMI generally collects information from you, treating and other doctors, allied health professionals, employers and investigators. CMI may disclose your personal information to medical practitioners, rehabilitation providers, legal practitioners and other experts or consultants for the purposes of assessing and managing your claim. CMI may disclose your personal information to your representative, if you have authorised us to do so in writing. CMI may also disclose your personal information to the State Insurance Regulatory Authority (SIRA) which is authorised to use that personal information to fulfil its functions under the NSW workers' compensation legislation. CMI will seek your consent before using or disclosing your personal information for any other purposes. CMI is unlikely to disclose your personal information to an overseas recipient.

CMI will handle your personal and health information in accordance with the *Privacy Act 1988* (Cth) and the *Health Records and Information Privacy Act 2002* (NSW). A copy of our privacy policy is available on our website. Our privacy policy contains information about how you can:

- access the personal information about you that is held by CMI;
- seek the correction of that personal information; or
- complain about a breach of the Australian Privacy Principles, and how we will deal with such a complaint.

If you would like any further information in relation to CMI's privacy policy or if you have any concerns about how CMI is managing your personal information, please contact our office on (02) 8270 3200.

## 6. Worker's declaration and consent

Print full name:

Date of birth:

I have read the information provided in this Worker's Injury Claim Form (including the Privacy Notice and the Worker's Declaration Consent (Form)). I declare that the information that I have supplied in this Form, and any attachments to this Form, is true and correct. I declare that I have not withheld any information, and that the injuries I have received were caused in the manner as set out in this Form, and in no other way whatsoever.

I authorise and consent to the collection, disclosure and use of my personal information in accordance with CMI's privacy policy and the above Privacy Notice.

I understand that while I am in receipt of weekly compensation benefits, I am required to notify CMI immediately if any of the following occur:

1. I commence employment with another employer or in my own business.
2. I commence my own business.
3. If I change my address.

I have read and acknowledge my obligation under Section 57 of the Workers' Compensation Act 1987 as set out below:

- (1) A worker who is in receipt of weekly payments of compensation shall forthwith notify the person making those payments of:
  - (a) the worker's commencing employment with some other person or in the worker's own business, or
  - (b) any change in that employment that affects the worker's earnings.
- (2) A worker is not guilty of an offence under this section if the worker satisfies the court that the person to whom the matter was to be notified failed to inform the worker of the obligation to notify that matter.
- (3) This section applies even though the weekly payments of compensation are payable under an interim payment direction by the Registrar.

I understand that if any information I have given is untrue or incorrect, that my Claim may be denied and that I may be prosecuted.

Signature of worker:

Date:

Signature of employer:

Date: