Coal Mines Insurance

Worker's Injury Claim Form

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: Mr
Surname: Citizen
Given name(s): John
Other/previous legal names:
Date of birth: 19/05/1976
Gender: Male ☑ Female ☐ Other ☐
Home address: 5 Main Street, Bulga
State: NSW
Postcode: 2330
Postal address (if different from above):
State:
Postcode:
Home phone number:
Mobile phone number: 04XX XXX XXX
Email address: citizenj@gmail.com

2. Employment details

Name of employer: Policyholder Pty Ltd
Address of employer:
Name of workplace where injury occurred: Policyholder Underground
Occupation: Miner
Year commenced in NSW coal mining industry: 2000
Basis of employment
Full time ☑ Part time ☐ Casual ☐
Contract ☐ If contract, state period:

3. Incident details

Date of incident: 22/02/2020
Time of incident: 10:50 am ☑ pm ☐
Date incident reported: 22/02/2020
Time incident reported: 10:55 am ☐ pm ☑
Name and position of person you reported the injury to: Bob Cat, Deputy
At the time of incident were you on your daily or periodic journey to or from work?
Yes ☐ ▶ Go to Section 4 No ☐
Time shift commenced on date of injury: 6:00 am ☑ pm ☐
Did you cease work as a result of injury?
Yes ☑ No ☐
If yes, date and time ceased: 22/02/2020 11:00 am ☑ pm ☐
Name of tool or machine being used at time of incident:
Were there any witnesses to the incident?
Yes ☐ No ☑
If yes, provide witness names and contact details:

4. Injury details

Part of body injured e.g. left upper arm, psychological: Lower back
Nature of injury e.g. fracture, sprain: Strain
Name of your treating doctor: Dr Seuss
SIRA Certificate of Capacity attached?
Yes ☑ No ☐
Have you returned to work with your employer?
Yes ☑ No ☐
If yes:
How many hours are you working? Full hours
What duties are you doing? Full ☐ Suitable/Light ☑
Explain in detail how your recent injury occurred and any task(s) being carried out at the time

Lifting 6" pipe from pipe trailer when felt sharp pain in lower back, right hand side

5. Previous injuries

Was the part of body affected by this injury healthy prior to this incident?
Yes ☑ No ☐

Have you previously had any surgery and/or treatment on this part of this body?
Yes ☐ No ☑

Have you previously had another injury or personal injury claim that relates to this injury?
Yes ☑ No ☐

If yes, please provide:

Details, including claim number(s) and insurer	BXXXXXX - CMI
Date of previous injury(s)	17/08/2013
Was this / were any of these work-related injury(s)?	Yes ☑ No ☐
If yes, please provide name of employer(s)	Policyholder Underground

6. Additional current employment

Do you currently have any other employment (paid or unpaid)?
Yes ☐ No ☑

If yes, please provide:

Employer's name and address	
Phone number	
Hours worked per week	

7. Dependants

Full and accurate information regarding dependants is required. The persons listed must be totally or mainly dependent on the claimant for support. If dependants receive no income write "NIL".

Do you support a spouse/partner?
Yes ☑ No ☐

If yes, please provide their:

Full name	Jane Citizen
Date of birth	14/09/1980
Weekly income	
Name of employer	

Do you support any dependant children?
Yes ☑ No ☐

If yes, please provide their:

	Full name	Date of birth	Weekly income
1	Joe Citizen	01/11/2007	
2			
3			
4			

Should any children claimed be in receipt of a weekly income, please provide the name(s) of their employer(s)

1
2
3
4

Should any children claimed as dependant be over 17 years of age, please complete the following

Full name

Is the child still attending school?	Yes ☐ No ☐
If yes, what school year are they in?	
If no, what date did they finish?	
Will the child leave school at the end of this term?	Yes ☐ No ☐
If yes, on what date?	
Will the child continue education at school, college or university next term?	Yes ☐ No ☐

8. Journey incident

Was your injury sustained whilst on a daily or other periodic journey to or from work?

Yes ☐ ▶ Complete parts **A** and **B**

No ☑ ▶ Go to **Privacy Notice** and **Workers Declaration and Consent**

Part A – Incident details

Usual starting time ____ am ☐ pm ☐

Usual ceasing time ____ am ☐ pm ☐

Exact time your journey commenced ____ am ☐ pm ☐

Mode of transport used

8. Journey incident (continued)

Was the injury sustained travelling to or from your home and place of employment?
Yes ☐ No ☐

If yes, describe exactly where the incident happened

Was the injury sustained travelling to or from a place other than your normal place of employment?
Yes ☐ No ☐

If yes, what was the purpose of the journey and who authorised it?

Was this your normal route taken on date of incident?
Yes ☐ No ☐

Did you deviate/interrupt in any way from your usual route?
Yes ☐ No ☐

If yes, provide reasons

How did the injury occur?

Did you consume any alcohol or drugs, including medication prior to the accident?
Yes ☐ No ☐

If yes, provide details

Have you lodged any other claim as a result of this incident? E.g. property damage, CTP, public liability etc.
Yes ☐ No ☐

If yes, specify the type of claim, name of the insurer and claim reference number

Part B – Witnesses

Were there any witnesses to the accident?
Yes ☐ No ☐

If yes, provide name(s) and contact details

Was there a motor vehicle (including your own) involved in the incident?

Yes ☐ ▶ Complete **Parts C** and **D**

No ☐ ▶ Go to **Privacy Notice** and **Workers Declaration and Consent**

Part C – Traffic incident details

Please provide details regarding the vehicle you were travelling in

Driver's name

Driver's address

Registration

Licence number Contact number

Owner's name

Owner's address

Licence number Contact number

Please describe the weather and road conditions

Please provide details regarding any other vehicle(s) involved in the incident (if more than one, please attach a separate list)

Driver's name

Driver's address

Registration

Licence number Contact number

Owner's name

Owner's address

Licence number Contact number

If you <u>do not</u> have the other drivers' details or vehicle registration

Provide reasons why e.g. other driver left the scene

What attempts you have made to identify the driver?

Describe other vehicle(s) involved e.g. colour, make, model, distinguishing marks or observations

Please attach any images/photographs you may have of the incident with this form

Part D – Reporting and locality

Was the incident reported to the police?
Yes ☐ No ☐

If yes, name of police station

Date reported Police Event Number

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.

Worker's declaration and consent

Print full name: John Citizen **Date of birth:** 19/05/1976

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. There is any change in my employment that affects my earnings.
4. Any of the abovementioned dependants cease to be dependent upon me.
5. 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 received by employer:**