



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	Surname
<input type="text"/>	<input type="text"/>
Given name(s)	Other/previous legal names
<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	
<input type="text"/>	
State	Postcode
<input type="text"/>	<input type="text"/>
Postal address (if different from above)	
<input type="text"/>	
State	Postcode
<input type="text"/>	<input type="text"/>
Home phone number	Mobile phone number
<input type="text"/>	<input type="text"/>
Email address	
<input type="text"/>	

### 2. Employment details

Name of employer
<input type="text"/>
Address of employer
<input type="text"/>
Name of workplace where injury occurred
<input type="text"/>
Occupation
<input type="text"/>
Year commenced in NSW coal mining industry
<input type="text"/>
Basis of employment
Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/>
Contract <input type="checkbox"/> If contract, state period: <input type="text"/>

### 3. Incident details

Date of incident	Time of incident
<input type="text"/>	<input type="text"/> am <input type="checkbox"/> pm <input type="checkbox"/>
Date incident reported	Time incident reported
<input type="text"/>	<input type="text"/> am <input type="checkbox"/> pm <input type="checkbox"/>
Name and position of person you reported the injury to	
<input type="text"/>	
At the time of incident were you on your daily or periodic journey to or from work?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	

Time shift commenced on date of injury
<input type="text"/> am <input type="checkbox"/> pm <input type="checkbox"/>
Did you cease work as a result of injury?
Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date and time ceased
<input type="text"/> am <input type="checkbox"/> pm <input type="checkbox"/>
Name of tool or machine being used at time of incident
<input type="text"/>
Were there any witnesses to the incident?
Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, provide witness names and contact details
<input type="text"/>

### 4. Injury details

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

## 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 the 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

Date of previous injury(s)

Was this / were any of these work-related injury(s)?

Yes ☐ No ☐

If yes, please provide name of employer(s)

## 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

Date of birth

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	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>
4	<input type="text"/>

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 do not 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:  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. 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: