Form 1: Imminently Fatal Asbestos-Related Disease

Claim for Compensation (worker)

Approved Form – AF2017-159 under s222 of the *Workers Compensation Act 1951* for the purpose of a person making a claim under s170(1A) of the *Workers Compensation Act 1951*

WHO CAN MAKE A CLAIM

You may be eligible for compensation if:

- you have been diagnosed with an **imminently fatal asbestos-related disease**; and
- you were a **worker connected to the Australian Capital Territory** when you were exposed to asbestos dust or fibres; and
- you have **not previously received any compensation**, including through a common law settlement, for this asbestos-related disease.

WHAT TO DO NEXT

If you are eligible to lodge an application for compensation:

- you must **complete this form** (Form 1);
- a prescribed doctor, who is a doctor in the field of oncology, respiratory medicine or cardio-thoracic surgery, must **complete the medical certificate** (Form 1a);
- you are able to **lodge your completed application directly with the Default Insurance Fund**;
- you should lodge your application **within 28 days** after being diagnosed with an imminently fatal asbestos-related disease, however, the Default Insurance Fund may allow **more time if needed to complete the form**.

WHERE TO SEND THE CLAIM FORM

You must send your completed claim form and supporting documents:

By post:
Default Insurance Fund
GPO Box 158
Canberra ACT 2601

OR

By email: DefaultInsurance@act.gov.au

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WHAT WE WILL DO

Once you have lodged your completed application and supporting documents the Default Insurance Fund will:

- determine whether you were a worker under the legislation at the time of your exposure;
- determine whether you were a worker in connection with the Australian Capital Territory;
- conduct evidence checks to verify the information you have provided;
- determine your claim within 28 days after you have lodged your completed application, however, in some cases the Default Insurance Fund may require longer to obtain historical records from employers and insurers; and
- if the Default Insurance Fund needs longer than 28 days to decide your claim you will be advised of this need and the reason why your claim is taking longer than 28 days to decide.

NEED MORE INFORMATION?

If you require assistance completing this form or if you need more information about how to make a claim, contact the Default Insurance Fund on (02) 6207 0131 or go to http://apps.treasury.act.gov.au/insurance-and-risk-management/default-insurance-fund.

ABOUT THE INFORMATION IN THIS FORM

The information in this form is required under the *Workers Compensation Act 1951*. Failure to provide the required information may result in delays in processing your claim or it being rejected.

The information in this form is used by the Default Insurance Fund to help determine your claim and your potential compensation entitlements. It is important that you have answered all the questions fully.

The information in this form will be treated confidentially. The Default Insurance Fund is governed by the Chief Minister, Treasury and Economic Development Directorate's Information Privacy Policy which can be accessed at http://www.cmd.act.gov.au/legal/privacy. In relation to your personal health information, this is covered by the *Health Records (Privacy and Access) Act 1997*.

The information you provide must be truthful. You must answer the questions fully and truthfully. Information provided that is knowingly false or misleading may result in a penalty under the *Criminal Code 2002*.

Right to information

Under the *Information Privacy Act 2014* you have the right to access your personal information held by the Default Insurance Fund. Requests for information must be made in writing to the Privacy Officer, Default Insurance Fund, GPO Box 158, Canberra ACT 2601.

DISCLOSING AND SHARING OF INFORMATION

The Default Insurance Fund needs to collect your personal information for the purpose of determining and managing your compensation claim and to assist the Default Insurance Fund in the performance of its functions and exercise its powers under the *Workers Compensation Act 1951* (the Act) and associated regulations.

In the course of managing your claim, the Default Insurance Fund may need to disclose and/or share your personal information to and/or with the following third parties:

- your employer at the time you were exposed to asbestos and any subsequent employer
- any health professional, hospital or other health institutions
- your case manager or workplace rehabilitation provider
- vocational and functional assessor
- employment agencies
- legal advisers
- persons engaged by the Default Insurance Fund to conduct research related activities
- any relevant third party (or insurer) considered by the Default Insurance Fund to have contributed to the injury
- any other person assisting the Default Insurance Fund in the performance of its functions or exercise of its powers.

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SECTION A: APPLICANT'S PERSONAL DETAILS

Please ensure that ALL the questions are answered to assist in processing your claim in a timely manner. If you have any questions about this form you may telephone the Default Insurance Fund on (02) 6207 0131.

1. Your Full Name

Title | Last Name

Given Name(s)

2. Birth Details

Gender | M | F | Other

Date of Birth

3. Address

Home Address

Street Address

Suburb | State | Postcode

Country

Postal Address (if same as home address please write 'AS ABOVE")

Street Address

Suburb | State | Postcode

Country

4. Contact Details

Home Phone | Work Phone | Fax

Mobile | Email

5. Has a prescribed doctor examined you and determined that you have or may have an imminently fatal asbestos-related disease?

Under the Act, a prescribed doctor is a doctor in one of the following specialty fields; oncology, respiratory medicine or cardio-thoracic surgery.

☐ Yes

☐ No, you must see a doctor for a diagnosis that you have an imminently fatal asbestos-related disease before you lodge this application.

What asbestos-related disease have you been diagnosed with?

Please note you must also submit a medical certificate from the doctor you see regarding your diagnosis

6. Additional Questions

Do you speak a language other than English at home? ☐ Yes ☐ No

If yes, what language?

Do you require an interpreter?* ☐ Yes ☐ No

If yes, what language?

***If you require an interpreter they must complete section E of this application**

Do you have any needs that affect how you access our services? e.g. disability, cultural, religious

If yes, please provide details

SECTION B: Employment, earnings and other compensation details

1. Are you currently employed or have you worked in the 12 month period before making this application?

YES ☐ If yes, please complete the following questions

NO ☐ If no, please go to question 3

a.) Normal weekly earnings (includes any regular allowances, but not travel or accommodation allowances. Overtime is excluded other than in specified circumstances.

b.) Normal weekly hours (hrs, mins)

c.) Average days usually worked per week

d.) Occupation

Please provide copies of at least two recent payslips

2. Details of current employer (if relevant)?

Employer

Employer contact name

Street name Suburb

State Postcode Country

Telephone number

When did you commence working with your current employer?

Please note that the Default Insurance Fund may contact your employer, or previous employer, to verify details of your employment.

3. Did you cease employment due to your current asbestos-related disease?

☐ Yes ☐ No

If yes, are you partially or totally incapacitated for work due to your asbestos-related disease?

☐ Yes, partially restricted for work ☐ Yes, totally restricted for work ☐ No

If yes, please provide details of how you are restricted, and when you commenced restricted duties.

If you ceased employment for a reason other than your asbestos-related disease please provide details.

On what date did you last work?

Do you intend to work again? ☐ Yes ☐ No

4. Do you have a disease or injury other than an asbestos-related disease?

☐ Yes ☐ No

If yes, please specify

Does this affect your ability to work or your daily living activities?

☐ Yes ☐ No

If yes, please specify

5. Do you receive any type of pension, benefit or allowance (including any overseas payment)?*

☐ Yes, give details below ☐ No

What is the type of pension, benefit or allowance?

What is the fortnightly rate?

*Please note that compensation payments may affect existing pensions and benefits or have implications for taxation. Please seek advice from Centrelink (1800 777 653) and the Australian Taxation Office www.ato.gov.au.

Please attach copies of any relevant documents

6. Have you claimed, received or are you receiving compensation or damages, or do you intend to claim compensation or damages from any other source (e.g. another State, the Commonwealth, overseas, common law through the courts, etc) for an asbestos-related disease, other than by this application?

☐ Yes, give details below ☐ No

Please attach copies of any relevant documents

SECTION C: Dependant details

1. Do you have any dependants*?

☐ Yes ☐ No

If yes, please complete the table below. The details below will assist the Default Insurance Fund in processing any subsequent claims by your dependants in relation to your claim.

Title	Name	Gender	Date of birth	Relationship to the worker
	First name: Middle name: Last name: Maiden name (if applicable):			
	First name: Middle name: Last name: Maiden name (if applicable):			
	First name: Middle name: Last name: Maiden name (if applicable):			
	First name: Middle name: Last name: Maiden name (if applicable):			
	First name: Middle name: Last name: Maiden name (if applicable):			
	First name: Middle name: Last name: Maiden name (if applicable):			

* A dependant of a worker is an individual who:

a.) is totally or partly dependent on the worker's earnings, or would have been apart from the worker's incapacity because of the asbestos-related disease,

AND

b.) who is a member of the worker's family^ or a person to whom the worker acted in place of a parent or who acted in place of a parent for the worker.

^ A member of the worker's family means the grandchild, child, stepchild, adopted child, sister, brother, half-sister, half-brother, domestic partner, parent, step-parent, mother-in-law, father-in-law or grandparent of the worker.

If a dependant(s) intends to make a dependants' claim they will need to complete a separate *Claim for Compensation (Dependants)* (Form 2) and provide evidence such as marriage certificate, proof of relationship, birth certificate etc.

SECTION D: Exposure History

1. Employment history

Applications must include details of your full work history. In addition, please provide as many details as you can regarding your asbestos exposure and your employment during the period you were exposed.

Please attach copies of any relevant documents such as:

- **payslips, group certificates or other relevant documents;**
- **evidence of trade union membership, or evidence of the holding of a licence, qualification or other authority to engage in a trade or occupation during the exposure period;**
- **a statutory declaration or affidavit sworn by you or another person such as a former work colleague regarding your employment during the exposure period;**
- **witness statements.**

Employment (include details of occupation and workplace)	**Employer** (please include employer name, employer address and ABN and ACN, if known)	If exposed, name of the asbestos product exposed to (if known/relevant)	**Period of employment** with employer	**Exposure period** (dates or time period in which the person was exposed to asbestos through their employment if applicable)	Where relevant, how were you exposed to asbestos / what activities were you undertaking at the time? For example using power tools on asbestos product, working with asbestos lagging, manufacturing asbestos product

Employment (include details of occupation and workplace)	**Employer** (please include employer name, employer address and ABN and ACN, if known)	If exposed, name of the asbestos product exposed to (if known/relevant)	**Period of employment** with employer	**Exposure period** (dates or time period in which the person was exposed to asbestos through their employment if applicable)	Where relevant, how were you exposed to asbestos / what activities were you undertaking at the time? For example using power tools on asbestos product, working with asbestos lagging, manufacturing asbestos product

If you require more space, please attach additional pages to your application

2. Asbestos exposure outside employment

Please use the table below to record any incidents of asbestos exposure outside work. For example, while undertaking renovations on a house.

Failure to include this information may affect your claim.

Situation where you were exposed (eg renovating)	Name of the asbestos product exposed to (if known)	**Exposure period** (dates or time period in which the person was exposed to asbestos)	How were you exposed to asbestos / what activities were they undertaking at the time? For example using power tools on asbestos product

If you require more space please attach additional pages to your application

SECTION E: Assistance with this Form

Part 1 is to be completed when the applicant is unable to read and complete this form without assistance.

Part 2 is to be completed if the applicant requires a translator to complete the form.

The applicant must also sign at the bottom this page.

1. The details in this application form were completed by me on behalf of the Applicant and the contents of the application and form were read by me to the Applicant and the Applicant indicated his/her consent and the truth of the answers contained herein.

Signature Date

Print Name

Relationship to Applicant

(eg competent person over the age of 18 years authorised by a Power of Attorney or appointed as Guardian)

2. I assisted in the completion of this application form by reading the application form and questions to the Applicant in the language and translated his/her/their responses to each question from the language to the English language. The Applicant indicated his/her/their consent and the truth of the answers contained herein.

Signature of Interpreter/Translator Date

Print Name

Signature of Applicant Date

Print Name

SECTION F: Authority

I authorise the Default Insurance Fund to:

(i) contact and obtain information and documents relevant to my claim under the *Workers Compensation Act 1951*, for the injury in respect of this application; and

(ii) provide information and documents so obtained;

from/to the persons specified in this authorisation.

Persons specified in this authorisation are: Centrelink; Medicare Australia; Australian Taxation Office; and any employer or former employer.

I have read the information on page 2 and 3 of this form about privacy, right to information, disclosing and sharing of information and understand the CMTEDD privacy policy.

Signature of applicant:

Date

SECTION G: Authority to collect Medical Information

I (name)

Of (address)

Date of Birth

hereby authorise and consent to the doctors, health professionals, hospitals or other health institutions or rehabilitation providers named below:

Treatment provider name	Address	Phone number

If you require more spaces please attach additional pages to your application.

who has/have examined/treated me for:

to discuss with and provide to the Default Insurance Fund, any reports, clinical notes or other relevant information or documents relating to this, or other related conditions.

I authorise and consent to any doctor, health professional, hospital or other health institution, the Default Insurance Fund and the above mentioned parties disclosing, releasing, or discussing records containing my personal medical information, between one another.

I understand that information obtained under this authority from doctors, and ambulance service or as part of clinical notes from hospitals may include general medical information relevant to my application.

I understand that the medical information is required for the purposes of determining and managing my compensation claim, to assist with my treatment and to assist the Default Insurance Fund in any actions authorised under the Act.

I authorise and consent to a photocopy of this Authority being sufficient evidence of my authority and consent to discuss or provide the medical information requested.

Signature

Date

SECTION H: Declaration

Please read this declaration carefully before signing.

- The Default Insurance Fund is authorised to obtain information and documents relevant to your claim for compensation for an imminently fatal asbestos-related disease.
- Your claim may be delayed if this declaration and the Authority's in Section F and Section G are not properly completed.
- It is an offence under the *Criminal Code 2002* to make false and misleading statements.
- The collection, use and disclosure of personal information by the Default Insurance Fund are governed by the *Information Privacy Act 2014*.

I, (full name)

of (address)

solemnly declare that, to the best of my knowledge, all the information given in this form is true and correct in every aspect.

I have ensured that all dependants listed in Section C have been made aware of everything in the claim form and this declaration.

Signature of applicant:

Date