Form 2D

[r. 6AA]

Workers' Compensation and Injury Management Act 1981

WORKERS' COMPENSATION CLAIM FORM FOR DEPENDANTS OF DECEASED WORKERS

If insufficient space attach relevant details. If you can't fill in this form yourself you may ask someone to help you. If the deceased had no dependants this form can be used to claim for statutory allowances only (e.g. funeral expenses). Please complete all questions except for the details requested on dependants (see below).

Applicant's Details

Full Name of Applicant — Surname ______ Other Names ______

Occupation ______ Relationship to deceased worker ______
i.e. Executor, spouse, de facto partner, son, daughter

Residential Address ______

Postcode ______ Telephone No. ______

Deceased Worker's Details

Full Name of deceased worker — Surname ______ Other Names ______

Sex ☐ Male ☐ Female Date of Birth / /

Worker's Occupation ______

Period of Employment ______

Residential Address immediately prior to death ______

Employer's Details

Full Name of Employer, including trading name ______

Address of worker's usual workplace or base ______
Postcode ______ Telephone No. ______

Major activity of workplace (e.g. footwear manufacturing, sheep farming) ______

Deceased Worker's Dependant/s Details

Do not complete the following question if you are claiming for statutory allowances only. Give full details of deceased worker's dependants as at the date of death:

Name of Dependant	Date of Birth	Residential Address	Occupation	Relationship to deceased worker	Dependency Wholly	Part
					✓ Tick Box	
					☐	☐
					☐	☐
					☐	☐

Details of Fatality

Was the death the result of a work-related injury and/or disease? ☐ Yes ☐ No

What was the cause of death? ______

What were the main tasks/duties of the deceased's employment when he/she suffered the injury and/or contracted the disease? ______

In the case of personal injury, when did it occur? Day of the week ______ Time ______ Date / /

Date of death if different. Date / /

Where did the injury occur? (e.g. Workshop floor, Hay Street, Cloverdale) ______

In the case of a disease, what was the date of death?	Date	/ /	Date of diagnosis	Date	/ /
If known, when was the deceased first incapacitated by the disease?	Date	/ /	Don't know	☐	

	YES	NO		YES	NO
Prior to this application, have any workers' compensation payments been received or applied for in respect of the deceased (i.e. weekly payments, medical expenses, lump sums).	☐	☐	Have you attached a copy of any official notice of the deceased's death?	☐	☐

If yes, please attach as much information as you can

Declaration

I, the undersigned, do hereby warrant the truth of the foregoing statements. I hereby authorise any medical practitioner to disclose to the deceased worker's employer or his/her insurer and WorkCover WA any information regarding the deceased worker's medical history. However, I do not authorise the release or testing of human tissue samples or human tissue material of any kind or for any purpose.

Signature ______________________ Date / /

Signature ______________________ Date / /

INSURER/SELF-INSURER DETAILS

Insurer/self-insurer to complete then detach and forward the duplicate of this notice to WorkCover WA, 2 Bedbrook Place, Shenton Park, WA 6008:

Name of insurer/self-insurer: ______________________ Date stamp of insurer/self-insurer

____

Policy number: ______________________

Claim number: ______________________

____

WCN: ______________________

____

Occurrence Details

Mechanism: ______________________

Agency: ______________________

Nature: ______________________

Body Locn: ______________________