Form 2D

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 Dependents’ 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:

<table>
<thead>
<tr>
<th>Name of Dependant</th>
<th>Date of Birth</th>
<th>Residential Address</th>
<th>Occupation</th>
<th>Relationship to deceased worker</th>
<th>Dependency Wholly Part</th>
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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, Cloveland)
In the case of a disease, what was the date of death?

<table>
<thead>
<tr>
<th>Date</th>
<th>Date of diagnosis</th>
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If known, when was the deceased first incapacitated by the disease?

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<th>Date</th>
<th>Don’t know</th>
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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).

<table>
<thead>
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<th>YES</th>
<th>NO</th>
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Have you attached a copy of any official notice of the deceased’s death?

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<th>YES</th>
<th>NO</th>
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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.

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**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: ______________________