Former Police Officers' Medical Benefits Scheme Claim

WA Police Force
Health and Safety Division
Level 9 Westralia Square
141 St Georges Terrace
Perth WA 6000
police.wa.gov.au

Insurance Commission of Western Australia

Level 15, Tower 2, Mia Yellagonga
5 Spring Street
Perth WA 6000

GPO Box L920
PERTH WA 6842

Tel:(08) 9264 3333
icwa.wa.gov.au

Police (Medical and Other Expenses for Former Officers) Act 2008

Form to be lodged with WA Police Force
Claims.WR@police.wa.gov.au

The Insurance Commission of Western Australia collects your personal information to assess and manage your claim. During the course of your claim, we will continue to collect other personal information from you and/or other relevant parties (including hospitals, medical providers, WA Police, Office of the Commissioner for Victims of Crime, other government agencies and other insurers) for the same purpose. Your information may be shared with other authorised parties where necessary and authorised by law. For further details on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

1. Former officer details

Family name:	Given name(s):
Date of birth:	Gender: M ☐ F ☐
Residential address:	
Postal address (if different):	Employee number (PD):
Phone:	Email:
Role/position details (at time of incident):	
Branch/location:	
Details of main tasks/duties performance at time of incident:	

2. Incident details

Has a work related claim previously been lodged with Western Australia Police Force? Yes ☐ If yes, provide details. No ☐			
Incident number:	Claim number:	Date of lodgement:	Place of lodgement:
Where did the incident occur (e.g. on road, in office)?			
Incident location (suburb):			
Date of incident:		Time:	am/pm
What were you doing at the time of the incident?			
To whom did you report the incident?			
Where did you report the incident (branch)?			
Describe the incident (what happened and what caused it):			

3. Witness details

Were there any witnesses to the incident? Yes ☐ If yes, provide details. No ☐	
Name:	
Address:	
Phone:	Email:

4. Injury details

What actually happened and what caused the injury? What action was involved, e.g. – fall, caught between, struck by moving object:
What object/machine/substance was involved, e.g. petrol fumes, wooden door frame:
Describe the most serious injury or disease caused by the occurrence, e.g. fracture, burn, cut, abrasion:
Describe the bodily location of the injury or disease, e.g. upper arm, ankle, eye:

5. Medical attention/history details

Is the present injury totally attributable to this incident? Yes ☐ No ☐ If no, provide details:	
Was the part of the body affected/injured by this incident healthy before the occurrence? Yes ☐ No ☐ If no, provide details:	
Details of medical practitioner(s) who have treated you for this injury:	
Usual medical practitioner name:	Phone:
Address:	
Medical practitioner name:	Phone:
Address:	
Medical practitioner name:	Phone:
Address:	
Medical practitioner name:	Phone:
Address:	
Provide details of the treatment you are currently receiving for the disease/injury:	

6. Previous compensation

Under Section 6 of the *Police (Medical and Other Expenses for Former Officers) Act 2008* you are not entitled to claim benefits under this scheme if you have previously received compensation for medical expenses. Have you received any form of compensation in relation to this injury?

Yes ☐ No ☐ If yes, provide details:

Type of compensation received: Common law ☐ Act of grace ☐ Criminal injury compensation ☐ Motor vehicle personal injury claim ☐

Other ☐ Specify:

Date of compensation:	Amount of compensation:	Reference number:

7. Current activities

Are you currently seeking compensation from any other source or involved in litigation to seek compensation for this injury?

Yes ☐ No ☐ If yes, provide details:

8. Declaration and consent authority

I declare that the particulars contained herein or annexed hereto are true to the best of my knowledge and belief. I authorise any medical practitioner who treats me (whether or not named on this form) to discuss my medical condition, in relation to my claim for post separation medical benefits with the Insurance Commission.

I understand the Insurance Commission may need to collect personal information about me from other individuals and organisations. These may include insurance companies, health service providers, rehabilitation service providers, risk assessors, loss adjusters, legal practitioners, other experts or consultants, and the Insurance Commission concerning claims under the *Motor Vehicle (Third Party Insurance) Act 1943*. I consent to these individuals and organisations disclosing personal information to the Insurance Commission to assess and manage my claim.

Signature:	Date:	Witness signature:	Date:

Please send the completed form and any relevant documents to Claims.WR@police.wa.gov.au

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PART 2

WA Police Force Health and Safety Division to complete this section

1. Employment and claim details

Date first employed:	Date of separation:
Date claim lodged with WA Police Force:	
Is the claim supported? Yes ☐ No ☐ If no, provide reasons:	

2. Declaration and authorisation

I declare that the details submitted are true and correct and that I am the person authorised to lodge the claim with the Insurance Commission on behalf of the WA Police Force.

Signature: Date:

Name:	Position Title:
Phone:	Email:

Please attach all relevant documents to assist with assessment of this claim.