Insurance Commission of Western Australia

Government Insurance Division

Level 13, Forrest Centre
221 St Georges Terrace
Perth WA 6000

GPO BOX K837
Perth WA 6842

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

Application for Industrial Disease Compensation by Worker

1. Claimant details

Last name:	First name:
Address:	
Phone:	Email:
Date of birth:	Are you under the care of a specialist? ☐ Yes ☐ No If yes, provide details below:
Name and address of specialist:	Name:
	Address:

2. Claim details

When and where did you first become aware that you were suffering from an industrial disease?	Date:
	Place:
Are you suffering from any other disorder which may be contributing to your disablement? ☐ Yes ☐ No	
If yes, nature:	

3. Current employment details (if applicable)

If you are currently employed complete details below, otherwise leave this section blank and move to section 4.

Name of current employer:		
Address of current employer:		
Current occupation:		
Current employment type:	☐ Permanent ☐ Temporary ☐ Casual ☐ Wages ☐ Salary	☐ Part-Time ☐ Full Time
Weekly wage amount:		

4. Mining industry employment details

Name and address of last employer in mining industry:	Name:
	Address:
Last occupation:	
Date ceased working:	How long employed by this employer? years months
Were you employed outside of Western Australia for a period of six months or more since last employed in the mining industry in WA? ☐ Yes ☐ No If yes, complete details below:	
Period of employment from:	To:

5. Pensions

Complete this section if you are in receipt of a pension.

Type of pension	
Weekly rate	Date payment commenced

6. Spouse details

Spouse last name:	First name:
Address:	
Number of wholly dependent children	Number of partially dependent children

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON THE DECLARATION ON THE FOLLOWING PAGE MAY DELAY A DECISION BY THE INSURANCE COMMISSION ON YOUR CLAIM.

7. Employment History

Provide names and addresses of all employers by whom you have been employed up to the date of the application (including any mining and any other employers, in date order). Attach a separate sheet if insufficient space.

Date from	Date to	Employer	Address	Employed as	Asbestos contact?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

8. Claimant declaration and authorisation

I declare that the details submitted are true and correct. I consent to the Insurance Commission and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my claim, including determining liability and whether my claim is true. This consent extends to the Insurance Commission disclosing my personal information, inclusive of sensitive information to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to the Insurance Commission disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*. I have read all the information on this form regarding the consent authority and I consent to the Insurance Commission dealing with my personal information in the manner described.

Signature: Date:

Witness name:

Witness signature: Date

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON THE DECLARATION ABOVE MAY DELAY A DECISION BY THE INSURANCE COMMISSION ON YOUR CLAIM.