Workers' Compensation and Rehabilitation Amendment Regulations (No. 6) 1999

Made by the Governor in Executive Council.

1. Citation

These regulations may be cited as the *Workers' Compensation and Rehabilitation Amendment Regulations (No. 6) 1999.*

2. Commencement

These regulations come into operation on the day on which section 20 of the *Workers' Compensation and Rehabilitation Amendment Act 1999* comes into operation.

3. The regulations amended

The amendments in these regulations are to the *Workers' Compensation and Rehabilitation Regulations 1982**.
[* *Reprinted as at 14 February 1995.*
For amendments to 14 October 1999 see 1998 Index to Legislation of Western Australia, Table 4, p. 354 and Gazette of 13 and 16 April, and 22 June 1999.]

4. Regulation 6 repealed

Regulation 6 of the principal regulations is repealed.

5. Regulation 6AA amended

Regulation 6AA of the principal regulations is amended after subregulation (2) by inserting the following subregulation —

"

(3) For a claim for compensation by dependants under section 84I(1)(b) of the Act (in the case of a death), the information required by Form 2D in Appendix I is prescribed under section 84I(2) of the Act.

".

6. Appendix I amended

(1) Appendix I to the principal regulations is amended by deleting Form 2A.

(2) Appendix I to the principal regulations is amended by inserting after Form 2C the following form —

"

Form 2D

Workers' Compensation and Rehabilitation Act 1981

Workers' Compensation Claim Form for Dependants of Deceased Workers

[r. 6AA]

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, Wife/defacto, 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 ☐	Dependency 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 ☐

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). YES ☐ NO ☐

Have you attached a copy of any official notice of the deceased's death? YES ☐ NO ☐

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 authorize 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.

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: _____

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By Command of the Governor,

M. C. WAUCHOPE, Clerk of the Executive Council.