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

ie. 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 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: