

APPLICATION TO RESOLVE A DISPUTE – PART XI

Office Use Only

Application No:

Related application number(s):

Applicant

Name:

(type/print in full)

Worker Employer Insurer

Other (please specify)

Respondent

Name:

(type/print in full)

Worker Employer Insurer

Filed by

Worker Worker representative
 Employer Employer representative
 Dependant Dependant representative
 Insurer Insurer representative

Other (please specify) Legal entity:

Contact telephone number:

NOTICE TO RESPONDENT

Workers have 21 days from the date of service of an application brought pursuant to section 60 or section 62 to reply by:

- filing a reply with the Dispute Resolution Directorate (DRD) at
2 Bedbrook Place, Shenton Park WA 6008; and
- serving a sealed copy of the reply on each other party

For all other applications, Respondents have 14 days to file a reply.

A Reply Form is available from DRD or on our website: www.workcover.wa.gov.au

Employers should contact their workers' compensation insurer before filing a reply.

Parties' Details

Worker Details

Surname/Family Name:

Given names:

Male Female Date of birth:

Occupation:

Postal address:

Telephone number:

Email address:

Telephone number for teleconference:

Address for service of documents:

Interpreter required? Yes No

If yes, what language (and dialect if applicable):

Please indicate if documents are to be served on representative/registered agent

Injury Details

Date of injury:

Nature of injury:

Describe how and where injury occurred:

Date notice of injury given to employer:

Date claim for compensation served on employer:

Worker Representative or Registered Agent details

Firm or organisation:

Address for service of documents:

Name of representative/registered agent:

Telephone number:

Fax number:

Email address:

Telephone number for teleconference:

Employer Details

Name of business/organisation:

WCN (if known):

Contact person:

Telephone number:

Fax number:

Email address:

Telephone number for teleconference:

Address for service of documents:

- Please indicate if documents are to be served on representative/registered agent
- If this application involves more than one employer, the additional employer cover sheet (Form 1A) must be completed and attached.

Insurer details

Name of insurer:

Claim number: WCCN (if known

Contact person:

Telephone number:

Fax number:

Email address:

Telephone number for teleconference:

Address for service of documents:

- Please indicate if documents are to be served on representative/registered agent
- If this application involves more than one insurer, the additional insurer cover sheet (Form 1B) must be completed and attached.

Employer/Insurer Representative or Registered Agent details

Firm or organisation:

Address for service of documents:

Name of representative/registered agent:

Telephone number:

Fax number:

Email address:

Telephone number for teleconference:

NATURE OF APPLICATION

Applicant to indicate type of orders sought.

Section of Act (if known):

What is the nature of the application?

Weekly payments - Worker's Application

Complete Section 1 only.

NOTE: You also have the option of lodging Part XII application for weekly compensation disputes of up to 12 weeks.

Weekly payments - Employer's Application

Complete Section 2 only.

NOTE: You also have the option of lodging Part XII application for weekly compensation disputes of up to 12 weeks.

Statutory Expenses - Worker's Application

Complete Section 3 only.

NOTE: You also have the option of lodging a Part XII application for the payment of statutory expenses that do not exceed the value of 5% of the prescribed amount.

Dependency

Only if claiming compensation after the death of a worker.

Complete Section 4 only.

Other

Complete Section 5 only.

Section 1. Weekly Payments – Workers' Applications

1.1 For commencement of payments From: To

1.2 For increase of payments From: (Date)

State grounds increase sought:

1.3 Beyond prescribed amount Commencing: (Date)

1.4 Determination of amount of compensation

Current amount \$ per week gross

Amount sought \$ per week gross

1.5 Was a notice advising of intention to reduce or cease payments received?

Yes No

If 'Yes', when was notice received? (Date)

Section 2. Weekly Payments – Employers' Applications

2.1 Reduction sought from (Present gross per week)

to (Gross per week)

from (Date)

2.2 Discontinuance sought from (Date)

2.3 Grounds for reduction or discontinuance:

Section 3. Statutory Expenses – Workers' Applications

3.1 Medical/hospital/other expenses (Provide specific details below)

3.2 Extension of Prescribed Amount (Provide specific details below)

Date	Nature of Expense	Name of Provider	\$

Section 4. Dependency (complete only if claiming compensation after death of worker)

Dependants

Name	D.O.B	Relationship to worker	Wholly/Partially dependent

Schedule 1 clause under which compensation is claimed

SUPPORTING DOCUMENTS AND INFORMATION

Documents and information attached to this application

Refer to Guide to Completing Part XI Application for a list of supporting documents and information to include with the application.

Medical Documents	Author	Specialty (eg Orthopaedics)	Date of Document

Non Medical Documents	Author	Date of Document

Documents and information you intend to use but do not yet have

MEDICAL

Nature of Evidence	Author	Specialty	Reason not available	Date of expected availability

NON MEDICAL

Nature of Evidence	Author	Intended use	Reason not available	Date of expected availability

Signature

Name:

(please print)

Signed:

Date:

THIS FORM MUST BE SIGNED OR IT WILL BE REJECTED

You can file completed applications with the DRD by:

Hand 2 Bedbrook Place
Shenton Park

Post 2 Bedbrook Place
Shenton Park WA 6008

Facsimile (08) 9388 5690 (Registry)

Note: The Application may only be lodged by fax if it has no more than 20 pages including annexure and cover sheet.

YOU CANNOT LODGE A DOCUMENT BY EMAIL