

## 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 <input style="width: 90%;" type="text"/>	Other Names <input style="width: 90%;" type="text"/>
	Occupation <input style="width: 90%;" type="text"/>	Relationship to deceased worker <input style="width: 90%;" type="text"/>
Residential Address	ie. Executor, Wife/defacto, Son, Daughter	
	Postcode <input style="width: 45%;" type="text"/>	Telephone No. <input style="width: 45%;" type="text"/>

#### **Deceased Worker's Details**

Full Name of deceased worker	Surname <input style="width: 90%;" type="text"/>	Other Names <input style="width: 90%;" type="text"/>
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>
Worker's Occupation	<input style="width: 90%;" type="text"/>	
Period of Employment	<input style="width: 90%;" type="text"/>	
Residential Address immediately prior to death	<input style="width: 90%;" type="text"/>	

#### **Employer's Details**

Full Name of Employer, including trading name	<input style="width: 90%;" type="text"/>	
Address of worker's usual workplace or base	Postcode <input style="width: 45%;" type="text"/>	Telephone No. <input style="width: 45%;" type="text"/>
Major activity of workplace (e.g. footwear manufacturing, sheep farming)	<input style="width: 90%;" type="text"/>	

#### **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
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

**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: \_\_\_\_\_