GOVERNMENT OF WESTERN AUSTRALIA

WorkCoverWA

Workers' Compensation Arbitration Service
2 Bedbrook Place
Shenton Park WA 6008
Ph 08 9388 5555
Fax 08 9388 5690
@WorkCoverWA
www.workcover.wa.gov.au

APPLICATION FOR ARBITRATION - WORKPLACE FATALITY Form 150A

Office use only

NOTES FOR APPLICANT

For further information or assistance in completing this form, please contact WorkCover WA's Advice and Assistance Line on 1300 794 744 or (08) 9388 5537 (TTY).

- Complete this form to apply to have a workplace fatality claim determined by the Workers' Compensation Arbitration Service under s72H(3).
- If the worker's death occurred before 1 July 2018, you must complete a Form 150.
- Attach a separate page(s) to this form if you do not have enough space.
- This form **must** be signed.
- Completed forms can be lodged by:

POST
Workers' Compensation Arbitration Service
WorkCover WA
2 Bedbrook Place
SHENTON PARK WA 6008

OR

FAX
on (08) 9388 5690

OR

IN PERSON
Workers' Compensation Arbitration Service
2 Bedbrook Place
SHENTON PARK WA 6008
Monday to Friday, 8am to 5pm

- Applications of more than 20 pages cannot be faxed.
- Forms cannot be lodged by email.

NOTES FOR RESPONDENT

- If liability for the claim for compensation has been accepted, a reply is not required to be lodged unless an Arbitrator or the Registrar order otherwise.
- If liability for the claim for compensation has not been accepted, a reply to this application outlining what is admitted and/or disputed, along with all supporting documents must be lodged within 14 days of the date of service of this application unless the time is abridged or extended by order of an Arbitrator or the Registrar.

SECTION A - APPLICATION DETAILS

1. Applicant *(party who is making application, e.g. dependant's name)*

2. Respondent *(party who application is against, e.g. employer's name)*

(Note: Form 161 to be completed if there are multiple respondents)

3. Lodged by *(tick relevant box)*

☐ Dependant ☐ Employer ☐ Insurer

☐ Dependant's representative ☐ Employer representative ☐ Insurer representative

☐ Other *(please specify)*

4. All notices from the Workers' Compensation Arbitration Service are sent by mail. Indicate if the applicant's preference is to receive notices by email. ☐ Email

5. Has the insurer accepted liability for the claim and the compensation sought?

☐ Yes - Proceed to Section B

☐ No - Proceed to Section C

SECTION B - ACCEPTED CLAIM

6. If liability has been accepted for the claim, attach the following documents and proceed to Section E:

- ☐ The claim form
- ☐ Insurer's notice of liability

Note: If the claim has been accepted, the insurer will provide the Workers' Compensation Arbitration Service with all other relevant documents.

SECTION C - CLAIM NOT ACCEPTED

7. If liability has **not** been accepted for the claim, attach the following documents:

- ☐ The claim form
- ☐ Insurer's notice of liability, if received
- ☐ All documents you intend to rely on for determination of the claim - complete Section D

Please note, if you have not been sent a notice of liability from the insurer/your employer, this application can only be made 30 days after you lodged the claim. Please contact WorkCover WA's Advice and Assistance Line on 1300 794 744 to discuss if required.

SECTION D - SUPPORTING DOCUMENTS AND INFORMATION

1. List documents and information attached to this application

Medical documents	Author/Doctor	Speciality	Date of document
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)

Non-medical documents	Author	Date of document
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)

2. List documents and information you intend to use but do not yet have

Medical

Nature of Evidence	Author/Doctor	Speciality	Reason not available	Date of expected availability
				(dd/mm/yyyy)
				(dd/mm/yyyy)

Non-medical

Nature of Evidence	Author	Intended use	Reason not available	Date of expected availability
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)

SECTION E - CONTACT DETAILS

8. Applicant details

Title (Mr/Mrs/ Ms/Miss/Dr)		Given names		Surname	
Male/Female		Date of birth		Relationship to worker	
Postal address					
City/Suburb			State	Postcode	
Phone		Fax		Mobile	
Email					
Interpreter required? (Yes/No)		Language/dialect			

9. Applicant representative's details *(if represented by a legal practitioner or registered agent)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

10. Employer details

Employer name					
Contact person					
Postal address					
City/Suburb			State	Postcode	
Phone		Fax		Mobile	
Email					

11. Employer representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

12. Insurer/self insurer details

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

13. Insurer/self insurer representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

14. Other party details (i.e. any other adult dependant)

Name					
Postal address					
City/Suburb		State		Postcode	
Phone		Fax		Mobile	
Email					
Interpreter required? (Yes/No)		Language/dialect			

15. Other party representative's details (if represented by a legal practitioner or registered agent)

Company name					
Contact person		Reference (if known)			
Phone		Fax		Mobile	
Email					

SECTION F - SIGNATURE OF APPLICANT

Signature

	Name	
	Date	