



 Workers' Compensation

 Arbitration Service

 2 Bedbrook Place

 Shenton Park WA 6008

 Ph
 08 9388 5555

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 ● WorkCoverWA

 www.workcover.wa.gov.au

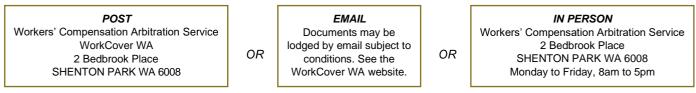
APPLICATION FOR ARBITRATION - WORKPLACE FATALITY Form 150A

Office use only

NOTES FOR APPLICANT

For further information or assistance in completing this form, please contact WorkCover WA's Advice and Assistance Service 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.
- You may lodge an Application for Arbitration Workplace Fatality online at https://online.workcover.wa.gov.au instead of using this form.
- 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:



- If lodging by post or in person, you must file the original application for arbitration and attachments with the Workers' Compensation Arbitration Service, plus a copy for each party.
- Sealed copies will be returned to you for service on the other parties.

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 to EDS (online) and to exempt parties by mail. Indicate if the applicant's preference is to receive notices by email.								

SECTION B - SUPPORTING DOCUMENTS AND INFORMATION

5. Attach the following documents

The Workplace Fatality Compensation Claim form

Insurer's notice of liability (if received)

Related documents as listed in Part 4 of the Compensation for Workplace Fatality – Guidelines for Claimants

All other documents you intend to rely on for determination of the claim

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 Service on 1300 794 744 to discuss if required.

a) List documents and information attached to this application

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

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

b) 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 C - CONTACT DETAILS

6. Applicant details

Title (Mr/Mrs Ms/Miss/Dr)	5/	Given	names			Surname		
Male/Fema	le	Date	of birth			Relationship to worker		
Postal add	address							
City/Suburl	D				State		Postcode	
Phone					-	Mobile		
Email								
Interpreter required? (Yes/No)			Language/dialect					

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

Company r	ame	ne						
Contact pe	Contact person Refe		Reference (if known)					
Phone				Mobile				
Email								

8. Employer details

Employer r	name				
Contact pe	rson				
Postal add	ress				
City/Suburl	C	State	e		Postcode
Phone				Mobile	
Email					

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

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

10. Insurer/self insurer details

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

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

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

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

Name								
Postal address	6							
City/Suburb					State		Postcode	
Phone						Mobile		
Email								
Interpreter required? (Yes/No)				Language/dialect				

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

Company nam	e				
Contact person			Reference (if known)		
Phone		Mo	obile		
Email					

SECTION D - SIGNATURE OF APPLICANT

Signature

Name
Date