[Address line]

Dear [insert name of claimant]

# Compensation claim for workplace fatality

We are notifying you that we have accepted your claim for compensation following the death of [insert name of worker]. The compensation entitlements are set out in the schedule to this letter.

A WorkCover WA arbitrator is required to make orders before we can pay compensation to any dependants.

An application to WorkCover WA’s Arbitration Service must be made before the compensation can be paid and can be lodged via WorkCover WA Online (online.workcover.wa.gov.au).

To support you with this process, and with your written consent, we can lodge the application on your behalf.

If you are legally represented your lawyer will lodge the application with WorkCover WA.

If you require assistance with the application process or have any questions, please contact WorkCover WA’s *Advice and Assistance Service* on 1300 794 744 or visit [www.workcover.wa.gov.au](http://www.workcover.wa.gov.au).

Yours sincerely

First Name Surname JOB TITLE

Date

cc WorkCover WA (communications@workcover.wa.gov.au)

**Schedule A – Compensation for which liability is accepted**

We *[insert name of insurer]* accept liability for the compensation payable to each of the dependants set out below in relation to the death of [*insert worker’s name*] and agree to a compensation order being made by an arbitrator on the following basis:

1. **Lump sum compensation [delete if not applicable]**

The lump sum entitlement of [*insert amount]* payable to [*name dependant, or if more than one dependant name each dependant and their respective share of the lump sum*].

1. **Child allowance [delete if not applicable]**

The child’s allowance payable to [*name each dependent child*]

1. **Funeral expenses [delete if not applicable]**

Funeral expenses up to [*insert current maximum amount*]

1. **Medical expenses [delete if not applicable]**

The amount of [*insert amount of medical expenses incurred by applicant*] for [*insert name of worker*] medical expenses.

1. **Lump sum compensation - death not a result of injury [delete if not applicable]**

The lump sum entitlement of [*insert amount*] payable to [*name dependant, or each dependant of more than one and their respective share*].

 Signed by/on behalf of *[insert name of insurer]*

|  |  |
| --- | --- |
| Signature |  |
| Name |  |
| Date |  |