Form 2 - Application to Resolve a Dispute

Notice to Parties

Notice to Parties

NOTICE TO APPLICANT

Form 2 is the correct form to use for a dispute or claim about:

- compensation for permanent impairment
- compensation for pain and suffering
- compensation for property damage
- domestic assistance

There are two forms available for referral of disputes concerning weekly payments and medical expenses.

Use the table below to decide the appropriate form.

Claim Type	Form Type
Weekly benefits work capacity only	Form 1
Weekly benefits up to 12 weeks and/or past medical expenses up to $9,722*	Form 2
Weekly benefits work capacity and past medical expenses greater than $9,722* and/or any future medical expenses	Form 2
Weekly benefits more than 12 weeks and/or past medical expenses greater than $9,722* and/or any future medical expenses	Form 2

Please note that the amount of $9,669.20 is subject to adjustment under Division 6 of Part 3 of the 1987 Act.

Form 2D is to be used for applications in respect of the death of a worker.

Failure to attach all relevant documents identified in this section will result in your application being rejected by the Commission

NOTICE TO RESPONDENT

You have 21 days from the date of registration of this application to respond by:

- lodging a reply with the Commission, and
- serving a sealed copy of the reply on each other party.

If you do not respond to the application, the Commission may progress the application in the absence of your reply.

Employers should contact their workers compensation insurer/scheme agent about lodging a reply.

NOTICE TO PARTIES

The application and the reply must accord with the Personal Injury Commission Rules 2021.

PRIVACY OF PERSONAL INFORMATION

The privacy of personal information is important to the Personal Injury Commission. The Commission collects personal information to register application forms and make decisions about disputes or claims. The NSW workers compensation laws permit the Commission to collect this information.

The Commission may give personal information to another person or agency (e.g. a doctor, a party, State Insurance Regulatory Authority) as required or authorised by law.

Commission decisions will be published. In some circumstances decisions may be de-identified or redacted before publication

A person has a right to access their personal information and correct any inaccuracies.

Application to Resolve a Dispute

Application Details

APPLICANT

The applicant can be a worker, dependant of a deceased worker, employer, and insurer/scheme agent* for the nominal insurer. But if the dispute is over permanent impairment / pain and suffering, only a worker can be the applicant.

The applicant applies to the Commission to resolve the dispute.

*Note: Insurer includes self and specialised insurers.

RESPONDENT

A respondent is a party to the dispute, other than the applicant. For example, if the applicant is a worker, the respondent is the employer.

The respondent responds to the application.

An applicant will need to complete an extra form if:

- The application involves more than one employer, or
- The employer is uninsured.

FILED BY NAME & FILED BY PARTY

Insert the name of the firm, organisation or individual filing the Form 2 and select the option that describes the firm, organisation or individual.

Examples:

- Worker's Legal Representative

A solicitor completes the Form 2 on behalf of a worker and files it with the Commission. In this case the representative inserts their firm/organisation in the 'Filed by Name' field and selects 'Worker's Representative' in the 'Filed By Party' field.

- Self-represented workers

If a worker completes and files the Form 2, the worker inserts their name in the 'Filed by Name' field and selects 'Worker' in the 'Filed By Party' field.

Applicant

Filed by Name

Filed by Party

Matters in Dispute

MATTERS IN DISPUTE

Indicate what the application is for by selecting the relevant box(es).

Example:

If the application is for weekly benefits compensation where work capacity in dispute and medical expenses compensation, select 'weekly benefits where work capacity in dispute' and 'medical expenses'.

Note: *The Commission is not able to accept a dispute for determination where compliance requirements have not been fulfilled.*

If you tick 'yes' for section 78/74/54, you must attach the section 78, 74 or section 54 notice

If you tick 'yes' for exchange of offers, you must attach the relevant correspondence

If you tick 'yes' for optional review requested, 14 days must have elapsed from the date of the request before you can lodge the Form 2 with the Commission and you must also attach the request.

- ☐ Weekly benefits where liability in dispute
- ☐ Weekly benefits where work capacity decision in dispute
- ☐ Medical expenses (where the amount is more than $9,468.10)
- ☐ Domestic assistance
- ☐ Compensation for property damage
- ☐ Lump sum compensation where liability in dispute
- ☐ Lump sum compensation where degree of permanent impairment is in dispute
- ☐ Compensation for pain and suffering

Compliance Documentation

- ☐ Decision notice/s attached
- ☐ Correspondence concerning exchange of offers attached
- ☐ Failure to determine

Workers claim to insurer and supporting document has been provided and will be attached to Documents section of this form?	◯ Yes	◯ No

Legal Assistance

Is the Applicant in receipt of a grant of legal assistance from the Independent Legal Assistance and Review Service (ILARS)?	◯ Yes	◯ No

Previous Proceedings, Claims and Assessments by Medical Assessors

PREVIOUS PROCEEDINGS, CLAIMS AND ASSESSMENTS BY MEDICAL ASSESSORS

Indicate whether or not the worker has been examined by a medical assessor or approved medical specialist in relation to this injury or if there are any:

- Previous or current related claims for the injury. Related claims or proceedings in the Personal Injury Commission, Workers Compensation Commission, Compensation Court, Supreme Court, District Court and Victims Compensation Tribunal.
- Section 66A agreements under the Workers Compensation Act 1987

Has the worker been examined at any time by a Medical Assessor under Part 7 of Chapter 7 of the Workplace Injury Management and Workers Compensation Act 1998 in respect of this injury or any other injury or condition?	◯ Yes	◯ No
Matter Number		
Have any proceedings been taken in relation to this injury or any other injury or condition?	◯ Yes	◯ No
Matter Number Court/Tribunal Details		
Has the injury been subject to a determination on liability?	◯ Yes	◯ No
Matter Number Details of awards or settlements received in relation to this injury		

Selection of Medical Assessor

SELECTION OF MEDICAL ASSESSOR

Where parties have agreed on a medical assessor, fill in the name otherwise mark the box indicating that the President is to appoint a medical assessor.

☐ The parties have agreed the following Medical Assessor may conduct the assessment

Name of Medical Assessor

☐ The Applicant agrees that the President appoint the Medical Assessor

Section 162

SECTION 162

If the Applicant seeks a declaration under section 162 of the Workers Compensation Act 1987:

1. Complete the Form 2
2. Complete the Section 162 section
3. Complete parts 1-6 only of the Form 2. Do not complete the first page
4. Attach the Section 162 Cover Sheet to the Form 2

The Section 162 Cover Sheet includes a request for the Commission to declare:

- a contract of insurance existed between the respondent and an insurer/scheme agent at the relevant time, and
- one of the circumstances in section 162(1) of the Workers compensation Act 1987 applies.

Is the Applicant seeking a declaration under section 162 of the Workers Compensation Act 1987	◯ Yes	◯ No

Insurer/Scheme Agent

Branch

The Respondent is

- ☐ a corporation that commenced to be wound up after entering into the contract with the insurer/scheme agent
- ☐ a corporation that has ceased to exist but has not commenced to be wound up
- ☐ a natural person and cannot be found after due inquiry and search
- ☐ a natural person and has died
- ☐ a natural person and permanently resides outside Australia
- ☐ an entity incorporated outside Australia and registered in Australia as a foreign company

Worker Details

Worker Details

Surname

Given Name(s)

Filed by Name

Title | Other Title | Date of Birth

☐ DX Address

Postal Address

Suburb | State | Postcode

☐ International Address | Country

Teleconference Phone | Home Phone

Mobile Phone

☐ I consent to receive SMS reminders from the Commission regarding appointments, etc.

Email

☐ Interpreter Required | Language of Interpreter

Details of any Special Needs of the Worker

☐ Worker has Representative

Worker Representative Details

Firm or Organisation

☐ Correspondence and documents to be sent to or served at address of representative

☐ DX Address

Postal Address

Suburb State Postcode

☐ International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

Employer Details

Employer Details

Organisation Name

ABN

☐ DX Address

Postal Address

Suburb State Postcode

☐ International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

☐ Employer is uninsured

The applicant seeks the following further orders:

1 A declaration that the employer was not insured as required by the Workers Compensation Act 1987 at the time of the worker's injury.

2 Orders:

(1) That the Nominal Insurer pay any compensation and costs awarded against the employer from the Workers Compensation Insurance Fund established under section 154D of the Workers Compensation Act 1987.

(2) That the employer reimburse the Nominal Insurer for:

(a) amounts paid out of the Insurance Fund in respect of compensation and costs awarded against the employer, and

(b) the costs of the Nominal Insurer.

Insurer / Scheme Agent Details

Insurer / Scheme Agent Details

Organisation Name

Branch Name

Claim Number

☐ DX Address

Postal Address

Suburb State Postcode

☐ International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

☐ This Insurer / Scheme Agent has a Representative

Insurer / Scheme Agent Representative Details

Organisation Name

☐ Correspondence and documents to be sent to or served at address of representative

☐ DX Address

Postal Address

Suburb State Postcode

☐ International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

Injury Details

Injury Details

Type of Injury

Date of Injury To ☐ Deemed Date

Date of Compensation Claim

Place of Injury

Injury Description /Cause of Injury and Death

Weekly Benefits Compensation

Weekly Benefits Compensation

Period of weekly compensation in dispute from To

Weekly amount in dispute

Dependants

Name

Date of Birth

Relationship to Worker

Pre 2012 Wages

Period from ☐ Ongoing Period To

Actual Earnings (s40(2)(B)) Comparable / Probable Earnings (s40(2)(A))

Current Weekly Wage Rate (s42)

Post 2012 Wages

Entitlement Period

Period from ☐ Ongoing Period To

PIAWE

Deductible amount “D” (for injuries received before 21 October 2019)

Able to earn/current weekly earnings

Additional Details
Industrial Award/Agreement (if applicable) Classification (if applicable) Note Any Changes to the Award During the Period Claimed (if applicable) Note Any Changes to the Acting in a higher position, or promotion (if applicable) Note Any Changes of Job During the Period Claimed (if applicable)

Medical, Hospital or Related expenses

Medical, Hospital or Related Expenses Details
Past treatment, care or related expenses Amount sought Details of past treatment, care or related expenses incurred Future treatment, care or related expenses Amount sought Details of future treatment, care or related expenses needed

Domestic Assistance

Domestic Assistance		
Is evidence of threshold requirement attached?	◯ Yes	◯ No
Has Domestic Assistance been claimed?	◯ Yes	◯ No
Amount Claimed		

Damage to Property

Damage to Property
Damage to Property Amount Claimed

Permanent Impairment/Pain and Suffering

Injury Details

Date of Injury To

Systems Claimed

Total WPI Percentage Total WPI Amount

Percentage of Pain and Suffering

Amount Claimed for Pain and Suffering

Date of Injury To

Systems Claimed

Total WPI Percentage Total WPI Amount

Percentage of Pain and Suffering

Amount Claimed for Pain and Suffering

Supporting Documents

Supporting Documents

Certification and Signature

Certification and Signature

The Applicant certifies that:

- The applicant is entitled to lodge this application because it satisfies the statutory procedural requirements under section 289 or section 289A of the Workplace Injury Management and Workers Compensation Act 1998 and clauses 44,45 and 46 of the Workers Compensation Regulation 2016.
- The dispute is limited to those matters identified in Part 1 of this form.

☐ Application signed Date signed