Workers Compensation Commission

Matter No:

(Office use only)

January 2019

Application

Application to Resolve a Dispute

This is the approved form to refer a dispute about a claim, pursuant to s288 of the 1998 Act.

Applicant:

Respondent:

Filed by:

☐ Worker ☐ Scheme agent* ☐ icare

☐ Worker representative ☐ Specialised insurer ☐ TMF Agent

☐ Employer ☐ Self-insurer

☐ Employer representative ☐ Insurer/scheme agent representative

**Note scheme agent means scheme agent for the nominal insurer*

Part 1 – Matters in Dispute

1.1 Claim to which dispute relates

☐ Weekly benefits where liability in dispute
☐ Weekly benefits where work capacity decision in dispute
☐ Medical expenses
☐ Domestic assistance
☐ Compensation for property damage
☐ Lump sum compensation where liability in dispute
☐ Lump sum compensation where degree of permanent impairment in dispute
☐ Compensation for pain and suffering

1.2 Compliance documentation (list all relevant attachments in Section 6)

☐ **Decision notice/s attached**

☐ **Correspondence concerning exchange of offers attached**
(Section 289(3)(b) & 289A(2)(b) of the 1998 Act)

☐ **Failure to Determine**
Where insurer fails to determine claim:
Worker's claim to insurer and supporting documents attached: ☐ Yes ☐ No

1.3 Legal assistance

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

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NOTICE TO APPLICANT

See Guide to Completing Form 2 as to when to use this form for weekly benefits compensation or medical expenses.

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.

The reply form (Form 2A) is available from the Commission's website at www.wcc.nsw.gov.au or from the Commission on 1300 368 040. 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 *Workers Compensation Commission Rules* 2011 and the Guide to completing Form 2 available on the Commission's website **www.wcc.nsw.gov.au**

PART 2 – Previous Proceedings, Claims and Assessments by Approved Medical Specialists

2.1 Has the worker been examined at any time by an Approved Medical Specialist 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?

☐ No ☐ Yes

If yes, give the Commission matter number and attach Medical Assessment Certificate(s)

2.2 Have any proceedings been taken in relation to this injury or any other injury or condition?

☐ No ☐ Yes

If yes, give the court/tribunal details and matter number(s)

2.3 Has this injury been subject to a determination on liability by the Workers Compensation Commission?

☐ No ☐ Yes

If yes, give the Commission matter number and attach Certificate(s) of Determination

2.4 Provide details of awards or settlements received in relation to this injury.
(Attach copies of awards/consent orders/section 66A agreements/complying agreements)

PART 3 – Parties Details

3.1 Worker details

Date of birth: / /

Title: ☐Mr ☐Ms ☐Mrs ☐Miss ☐Dr ☐Other

Surname/Family name: Given name(s):

Postal address: Postcode:

Phone number for teleconference:

Email address:

Home phone number:

Mobile phone number:

☐ *Cross this box if correspondence and documents are to be sent to or served at address of representative*

Indicate language if the worker needs an interpreter:

Indicate any special needs of the worker:
(e.g. wheelchair access)

Preferred city/town/region for conciliation conference/arbitration hearing:
Where a preferred location is not nominated, the conference or arbitration location will be Sydney.

3.2 Worker representative details

Complete this section only if the worker has a representative

Firm or organisation:

Postal or DX address: Postcode:

Street address: Postcode:
(where interpreter required)

Name of representative:

Phone number for teleconference:

Email address:

Phone number:

3.3 Employer details

Name of business/organisation:

ABN:

Postal or DX address: Postcode:

Contact person:

Phone number for teleconference:

Email address:

Phone number:

3.4 Insurer/scheme agent details

Claim number:

Name of insurer/scheme agent:

Postal or DX address: Postcode:

Contact person:

Phone number for teleconference:

Email address:

Phone number:

Period of risk (if more than one insurer/scheme agent): From: / / To: / /

☐ *Cross this box if this application relates to more than one insurer/scheme agent (additional insurer/scheme agent schedule must be attached)*

3.5 Employer/insurer/scheme agent representative details

Complete this section only if the employer/insurer/scheme agent has a representative

Firm or organisation:

Postal or DX address: Postcode:

Name of representative:

Phone number for teleconference:

Email address:

Phone number:

PART 4 – Injury Details

Date of injury: / / Date of notice of injury: / /

Type of injury:

Place of injury:

Date of compensation claim: / /

Injury description:

PART 5 – Claim Details

5.1 Weekly benefits compensation	
Period of weekly compensation in dispute	**Weekly amount in dispute**
/ / to / /	$
/ / to / /	$
/ / to / /	$

Dependants

Name	Date of Birth	Relationship to Worker
	/ /	
	/ /	
	/ /	

5.2(a) Schedule of Earnings (Pre 2012 amending Act – existing recipients and exempt worker)			
Period From/To	**Actual earnings** (s40(2)(b))	**Comparable/ probable earnings** (s40(2)(a))	**Current weekly wage rate** (s42)
--	$	$	$
--	$	$	$
--	$	$	$

5.2(b) Schedule of Earnings			
Period From/To (First 13 weeks, s36)	**Pre-injury AWE**	**Deductible amount** (where applicable)	**Able to earn/current weekly earnings**
--	$	$	$
--	$	$	$
--	$	$	$

Period From/To (Weeks 14-130, s37)	**Pre-injury AWE**	**Deductible amount** (where applicable)	**Able to earn/current weekly earnings**
--	$	$	$
--	$	$	$
--	$	$	$

5.2(b) Schedule of Earnings			
Period From/To (After week 130, s38)	**Pre-injury AWE**	**Deductible amount** (where applicable)	**Able to earn/current weekly earnings**
--	$	$	$
--	$	$	$
--	$	$	$

5.3 Medical, hospital and rehabilitation expenses

Past treatment, care or related expenses:

Amount sought for past treatment: $

Details of past treatment, care or related expenses incurred:

Future treatment, care or related expenses:

Amount sought for future treatment: $

Details of future treatment, care or related expenses needed:

5.4 Domestic assistance

Please attach your evidence that you meet the threshold requirements for a domestic assistance claim

☐ Evidence of threshold requirement attached: ☐ Yes ☐ No

Domestic assistance claimed: ☐ Yes ☐ No

Amount claimed: $

5.5 Damage to property

Damage to property:

Amount claimed: $

5.6 Permanent impairment including pain and suffering

Permanent Impairment *Claim under Table of Disabilities or Whole Person Impairment (WPI)* *Use correct terminology depending on date of injury*		**Percentage**	**Amount claimed**
Date of Injury	**Body Parts/Systems Claimed**		
/ /		%	$
	Pain and suffering	%	$

5.7 Selection of Approved Medical Specialist

☐ The parties have agreed on the following Approved Medical Specialist to conduct the assessment.

Name of Approved Medical Specialist:

☐ The parties request the Registrar to appoint the Approved Medical Specialist.

PART 6 – Supporting Documentation

Note: *Supporting documentation is limited to documents that have been exchanged between the parties as and when required by the Workplace Injury Management and Workers Compensation Act 1998 and any regulation or guideline made under that Act, and by the Workers Compensation Commission Rules 2011*

Refer to the Guide for the preferred order of documents to be attached.

Document	**Author**	**Date of Document** (in chronological order)	**Start Page**
STATEMENT OF WORKER		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

PART 7 – 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.

Applicant's (or representative's) signature:_____ Date: / /

Lodgment Details

Hand delivery	Level 20, 1 Oxford Street Darlinghurst NSW 2010
Postal address	PO Box 594 Darlinghurst NSW 1300
Document exchange	DX 11524 Sydney Downtown
Electronic lodgment	registry@wcc.nsw.gov.au

Privacy of Personal Information

The privacy of personal information is important to the Workers Compensation 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.

Decisions by the Commission will generally be published, including on the Internet, unless there are exceptional circumstances justifying the decision being withheld.

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