Workers Compensation Commission

Matter No:

/20

(Office use only)

FORM 1

Application for Expedited Assessment

January 2019

Application

Application for Expedited Assessment

This is the approved form to apply for resolution of a dispute about an interim payment direction, past weekly benefits not more than 12 weeks, and weekly benefits where work capacity decision in dispute.

Applicant:

Respondent:

Filed by:

☐ Worker ☐ Insurer/scheme agent*

☐ Worker 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 compensation up to 12 weeks
☐ Weekly benefits where work capacity decision in dispute
☐ Past medical expenses compensation (where the amount is not more than $9,389.00 as indexed)

1.2 Compliance documentation **(please include all relevant attachments)**

☐ **Decision notice/s attached** ☐ Yes ☐ No

☐ **Failure to Determine (do not complete for provisional payment)**

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

January 2019

PART 2 – Service

Date served on other parties: / /

Method of service:

Party/person served:

Address of party/person served:

Date served on other parties: / /

Method of service:

Party/person served:

Address of party/person served:

NOTICE TO APPLICANT

Form 2 is to be used where the period of weekly benefits compensation in dispute is more than 12 weeks, and/or where the amount of past medical expenses claimed is more than $9,389.00 (as indexed) and/or weekly benefits where work capacity decision in dispute

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

NOTICE TO RESPONDENT

The Respondent has 7 days to serve the applicant and lodge a reply on Form 1B with the Commission.

The reply form (Form 1B) 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, Practice Direction No. 10, Practice Direction No. 15 and the Guide to completing Form 1 available on the Commission's website www.wcc.nsw.gov.au

PART 3 – Related Claims

Any current or related claims for the injuries? ☐Yes ☐ No

If yes, provide details:

Court/tribunal and matter number (if disputed claim):

Parties names (if different from these proceedings):

Status of claim:

Details of amounts received or paid: (attach copies of any award/order/agreement)

PART 4 – Parties Details

4.1 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:

☐ *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)

4.2 Worker representative details

Complete this section only if the worker has a representative

Firm or organisation:

Postal or DX address: Postcode:

Name of representative:

Phone number for teleconference:

Email address:

Phone number:

4.3 Employer details

Name of
business/organisation:

ABN:

Postal or DX address: Postcode:

Contact person:

Phone number for teleconference:

Email address:

Phone number:

4.4 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:

4.5 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 5 – Injury Details

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

Type of injury:

Place of injury:

Date of compensation claim: / /

Injury description:

Has the worker returned to work? ☐ Yes ☐ No (If Yes, provide date of return to work): / /

Part 6 – Claim Details

6.1 Weekly benefits compensation

Period of weekly compensation in dispute	Weekly amount in dispute
/ / to / /	$
/ / to / /	$
/ / to / /	$

Dependants

Name	Date of Birth	Relationship to Work
	/ /	
	/ /	
	/ /	

6.2(a) Schedule of wages claimed (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)
--	$	$	$
--	$	$	$
--	$	$	$

6.2(b) Schedule of wages claimed

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
--	$	$	$
--	$	$	$
--	$	$	$

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

6.4 Past medical, hospital and rehabilitation expenses

To be used for medical disputes less than $9,389 (as indexed)

Amount sought: $

Treatment, care or related expenses incurred or needed:
(attach schedule of expenses as shown in the Guide to Completing Form 1)

PART 7 – 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 Guide for the preferred order of documents to be attached

Document	Author	Date of Document (in chronological order)	Start Page
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

PART 8 – 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 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
Facsimile	1300 368 018

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.