



Workers' Compensation Dust Diseases Board of NSW

# APPLICATION BY DEPENDANT/S OF A DECEASED WORKER FOR COMPENSATION

WORKERS' COMPENSATION (DUST DISEASES) ACT 1942

**This form should be used in circumstances where the deceased  
worker has made a previous successful application**

If you require an interpreter to assist you to complete this form, please contact the Workers' Compensation (Dust Diseases) Board toll free on 1800 550 027.

#### Arabic

إذا احتجت إلى مترجم ليُساعدك في إكمال هذا النموذج ، نرجوك الاتصال بهيئة تعويضات العمل (أمراض الغبار) ،  
Workers' Compensation (Dust Diseases) Board على الرقم المجاني 1800 550 027 .

#### Croatian

Ako trebate tumača koji bi vam pomogao popuniti ovaj obrazac, molimo kontaktirajte Upravu za radničke odštete (bolesti prouzrokovane prašinom) - Workers' Compensation (Dust Diseases) Board - na besplatnom broju 1800 550 027.

#### Dutch

Indien u een tolk nodig heeft om u te helpen met het invullen van dit formulier, gaarne contact opnemen met de Werknemersongevallenverzekeringsraad (stofziekten) tel. 1800 550 027 (lokaal tarief).

#### Greek

Αν χρειάζεστε διερμηνέα για να συμπληρώσετε το έντυπο αυτό, παρακαλείστε να τηλεφωνήσετε στο Συμβούλιο Εργατικών Αποζημιώσεων (Ασθένειες Προκληθείσες από την άμμο) Workers' Compensation (Dust Diseases) Board στον αριθμό χωρίς χρέωση 1800 550 027.

#### Italian

Se avete bisogno dell'assistenza di un interprete per compilare questo modulo, potete contattare il Workers' Compensation (Dust Diseases) Board al numero verde 1800 550 027.

#### Maltese

Jekk teħtieġ interpretu/a biex jgħinek/tgħinek timla il-formola, jekk jogħġbok ċempel bla ħlas lil Bord tal-Kumpens għall-Ħaddiema (Dust Diseases) fuq in-numru 1800 550 027.

#### Polish

Jeśli potrzebujesz tłumacza by wypełnić ten formularz, skontaktuj się z: Workers' Compensation (Dust Diseases) Board, bezpłatnie pod numerem 1800 550 027.

#### Serbian

Ako vam je potrebna pomoć tumača da popunite ovaj formular, molimo vas da kontaktirate Workers' Compensation (Dust Diseases) Board (Komisiju za utvrđivanje odštete zbog povrede na radu – Bolesti izazvane prašinom) na besplatan broj 1800 550 027.

#### Turkish

Bu formu doldurmanıza yardımcı olacak bir tercümana ihtiyacınız varsa ücretsiz olan 1800 550 027 numaralı telefondan Workers' Compensation (Dust Diseases) Board'u (İşçi Tazminat Kurumu Toza Bağlı Hastalıklar Bölümü) arayınız.

# A: Particulars relating to/or concerning DEPENDENT SPOUSE of the deceased worker

**1. Your Full Name (Use BLOCK LETTERS)**

Mr     Mrs     Miss     Ms     Other

Family Name \_\_\_\_\_

First Given Name \_\_\_\_\_ Second Given Name \_\_\_\_\_

**2. Sex (Please tick ✓)**

Male     Female

**3. Date of Birth**

|   |   |   |   |   |   |
|---|---|---|---|---|---|
|   |   |   |   |   |   |
| D | D | M | M | Y | Y |

**4. Country of Birth**

\_\_\_\_\_

**5. Do you need an interpreter? (Please tick ✓)**

Yes     No    Language \_\_\_\_\_

**6. (a) Home Address (the address where you live)**

\_\_\_\_\_

\_\_\_\_\_

**(b) Postal Address (If same as home address write 'AS ABOVE')**

\_\_\_\_\_

\_\_\_\_\_

**7. Contact Details**

Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

Mobile ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email \_\_\_\_\_

8. Weekly income INCLUDING any pension payments at date of spouse's death

\_\_\_\_\_

9. Source of income (If no income, please state 'NIL')  
Please attach proof of your weekly/fortnightly income

\_\_\_\_\_

\_\_\_\_\_

## **B: Particulars relating to/or concerning DEPENDENT CHILD/REN of the deceased worker**

10. Family Name \_\_\_\_\_

First Given Name \_\_\_\_\_ Second Given Name \_\_\_\_\_

Date of Birth 

|   |   |   |   |   |   |
|---|---|---|---|---|---|
|   |   |   |   |   |   |
| D | D | M | M | Y | Y |

Relationship to Deceased Worker

\_\_\_\_\_

Address (if different to Deceased Worker)

\_\_\_\_\_

\_\_\_\_\_

Weekly amount and source of income at worker's date of death

\_\_\_\_\_

\_\_\_\_\_

Please complete the above for each dependant child. If more than one child please attach a separate page.

## **C: Particulars relating to/or concerning the DECEASED WORKER** (Please include a copy of the Death Certificate)

11. Family Name \_\_\_\_\_

First Given Name \_\_\_\_\_ Second Given Name \_\_\_\_\_

Date of Death 

|   |   |   |   |   |   |
|---|---|---|---|---|---|
|   |   |   |   |   |   |
| D | D | M | M | Y | Y |

 Place of Death \_\_\_\_\_

Last Residential Address

\_\_\_\_\_

\_\_\_\_\_

# Declaration by Applicant

## NOTES:

1. The Workers' Compensation (Dust Diseases) Act 1942 requires the Board to collect, hold and disseminate this information in determining your claim. All personal information provided to the Board is stored securely. You can access your personal information held by the Board by making a written request under the current State or Commonwealth Privacy Legislation and the Board will undertake any corrections to personal information where necessary.
2. Please read the Board's Privacy Disclosure Statement before signing this Declaration.
3. This Declaration must be witnessed by a person over the age of 18 years, not being a relative of the Applicant, who has known the Applicant for a minimum of 12 months and is an Australian citizen.
4. This Declaration may in certain circumstances be witnessed by an employee of the Board and in such cases you will need to provide one of the three combinations of documents to confirm your identity:
  - (a) Two documents, one from category A and one from category B, or
  - (b) Two documents from category B, or
  - (c) Three documents, one from category B and two from category C

| Category A  | Category B  | Category C  |
|---|---|---|
| Current driving licence (issued by an Australian State or Territory)<br>Australian passport | Medicare card (issued by the Health Insurance Commission)<br>Centrelink card (issued by Centrelink)<br>Department of Veterans' Affairs (DVA) card (issued by DVA)<br>Credit card or account card (issued by a financial institution in Australia) | Utilities bills e.g. telephone, electricity or gas bill<br>Bank statements showing your residential address<br>Property rates notice<br>Home insurance papers |

I hereby declare that the information supplied and the replies given in this application are, to the best of my belief, true in every respect.

I am aware that the regulations under the Act provide that an Applicant who fails without just cause or excuse to furnish full and correct information in support of their Application or when required by the Workers' Compensation (Dust Diseases) Board or the Medical Authority shall be liable to a penalty under the Act.

I acknowledge that I have been given, and have read, a copy of the Board's Privacy Disclosure Statement and I authorise the Medical Authority and the Board to collect, hold and disseminate my personal information in accordance with such statement for the purposes of processing my application for compensation as well as for Board approved medical research purposes and for the Board's investigation and assessment of other claims involving the same employers.

Signature of Applicant

Signature of Witness

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Date

|   |   |   |   |   |   |
|---|---|---|---|---|---|
|   |   |   |   |   |   |
| D | D | M | M | Y | Y |

Full Name

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Occupation

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### This form should be addressed to:

Workers' Compensation (Dust Diseases) Board  
Level 2  
82 Elizabeth Street  
Sydney NSW 2000

Address

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Telephone: (02) 8223 6600

Facsimile: (02) 8223 6699

Toll Free: 1800 550 027

Contact Telephone No

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Email: [enquiries@ddb.nsw.gov.au](mailto:enquiries@ddb.nsw.gov.au)

Web: [www.ddb.nsw.gov.au](http://www.ddb.nsw.gov.au)



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