



Workers' Compensation Dust Diseases Board of NSW

APPLICATION BY DEPENDANT OF A DECEASED WORKER FOR WORKERS' COMPENSATION ENTITLEMENT

WORKERS' COMPENSATION (DUST DISEASES) ACT 1942

This form should be used in circumstances where the deceased worker never made an application to the Board for compensation or made a prior unsuccessful application for compensation

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 telefonda Workers' Compensation (Dust Diseases) Board' u (İşçi Tazminat Kurumu Toza Bağlı Hastalıklar Bölümü) arayınız.

PART A: PARTICULARS RELATING TO THE DECEASED WORKER

Please ensure that ALL the questions are answered to assist us in processing your claim in a timely manner. If you have any questions about this form you may telephone us toll free on 1800 550 027 or (02) 8223 6600.

1. Name in Full of Deceased Worker (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 of the Deceased

_____|_____|_____|_____|_____|_____|
D D M M Y Y

4. Country of Birth of the Deceased

5. Date and Place of Death of the Deceased

Please provide a copy of the Death Certificate.

6. (a) Home Address (the address where the deceased last lived)

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

7. Did the deceased worker suffer from any dust-related disease or condition? If yes, give details.

8. (a) Name of the Deceased Worker's Doctor / General Practitioner

(b) Address of Doctor / General Practitioner

(c) Telephone No. of Doctor / General Practitioner

9. (a) Name of Deceased Worker's Respiratory Physician / Specialist (if applicable)

(b) Address of Respiratory Physician / Specialist

(c) Telephone No. of Respiratory Physician / Specialist

10. (a) Name of Deceased Worker's Oncologist / Surgeon (if applicable)

(b) Address of Oncologist / Surgeon

(c) Telephone No. of Oncologist / Surgeon

11. (a) Did the deceased worker suffer from any other illnesses or conditions requiring specialist medical treatment or hospitalisation? If yes, give details.

(b) Name of all other treating specialists

(i) Name of medical specialist / type of specialty

(ii) Address of medical specialist

(iii) Telephone No. of medical specialist

(iv) Illness or condition treated

(if more than one specialist, attach list)

12. Do you have any medical evidence relating to the deceased's medical condition?
(i.e. doctors reports, pathology results, x-ray/CT scan films).

(Please tick ✓)

Yes, please provide copies.

No

If you are unable to provide copies, please advise where this information may be obtained.
(i.e. name of hospital and date of admission etc.)

Please provide copies of all medical evidence.

13. Did the deceased worker have any NON-OCCUPATIONAL dust exposure?
(e.g.during home renovations etc.)

14. Did the deceased worker receive compensation from any other source (e.g. another State, the Commonwealth, overseas, etc.) for an incapacity or disablement from any injury or disease?
If yes, give details.

15. Did the deceased worker claim compensation or do you intend to claim compensation from any other source (e.g. another State, the Commonwealth, overseas, etc.) other than by this application?
If yes, give details.

PART B: Particulars Relating to the Dependant of Deceased Worker

17. Your Full Name (Use BLOCK LETTERS)

Mr Mrs Miss Ms Other

Family Name _____

First Given Name _____ Second Given Name _____

18. Sex (Please tick ✓)

Male Female

Date of Birth

D	D	M	M	Y	Y

19. Relationship to Deceased Worker

20. Country of Birth

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

Yes No Language _____

22. (a) Home Address (the address where you live)

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

23. Contact Details

Home () _____ Business () _____

Mobile () _____ Fax () _____

Email _____

24. Did you receive any type of pension, benefit or allowance at the time your spouse/partner died?

(a) What was the type of pension, benefit or allowance

(b) What was the fortnightly rate

Please provide copies, from the agency paying the pension, of any relevant correspondence, payslip or other recent confirmation as to your current benefit received from Centrelink, Veteran Affairs or any insurance company or superannuation fund.

25. Did you receive income from any other source at the time your spouse/partner died?

E.g. wages, workers compensation, superannuation, rental income, managed investments, shares, bank interest, etc.

(Please tick ✓)

Yes

No

If Yes, please state:

(a) Source of income

(b) Amount

(c) Frequency (weekly, fortnightly, monthly, quarterly)

Please provide copies, from the agency / organisation you receive an income from of any relevant documents.

26. Have you taken or do you intend to take any Court action against any party for damages in respect of the disease to which this application for compensation relates?

(Please tick ✓)

Yes, please advise the name and address of your solicitor

No

Undecided, please inform the Board if you subsequently commence proceedings against any other party

27. Please provide details of all dependent children including full time students aged between 16 and 21 years. Please complete for each dependant child. If more than one child please attach a separate page.

(NB: dependent child includes natural children, step children, foster children and adopted children)

Family Name _____

First Given Name _____ Second Given Name _____

Relationship to Deceased Worker

Address (if different to Deceased Worker)

Date of Birth

D	D	M	M	Y	Y

Degree of dependency (i.e. wholly/partially*)

Name and address of school or other educational institution if aged between 16 – 21

*NB:

Wholly Dependent

Dependant who does not have their own income.

Partially Dependent

Dependant who receives their own income from another source but may still be partially dependent on the worker for income.

Please provide a copy of your dependant(s) group certificate, letter from employer, income tax return or payslips as proof of weekly earnings. If you have an enterprise agreement please provide a copy as proof of weekly earnings.

PART C: Checklist of information/documents

The following checklist will help you complete the form correctly and minimise the need for us to ask you for further information.

Information required for Workers' Compensation Entitlement – Part A

- Provide a copy of the Death Certificate. (Please refer to **Question 5 of Part A**)
- Provide copies of all medical evidence. (Please refer to **Question 12 of Part A**)
- Ensure you include all details in relation to employment of the deceased worker in NSW, interstate and overseas. (Please refer to **Question 16 of Part A**)
- Attach documents confirming employment of the deceased worker e.g: group certificate, references or termination statement. (Please refer to **Question 16 of Part A**)

Information required for Workers' Compensation Entitlement – Part B

- Attach copies, from the agency paying the pension, of any relevant correspondence, payslip or other recent confirmation as to your current benefit received from Centrelink, Veteran Affairs or any insurance company or superannuation fund. (Please refer to **Question 24 of Part B**)
- Attach copies, from the agency/organisation you receive an income from, of any relevant documents. (Please refer to **Question 25 of Part B**)
- Attach a copy of your dependant(s)/child(ren) group certificate, letter from employer, income tax return, payslips and enterprise agreement if applicable. (Please refer to **Question 27 of Part B**)
- Ensure that you have read the Board's Privacy Disclosure Statement before signing the Declaration by Applicant (**PART D**)
- Ensure that the Declaration by Applicant (**PART D**) is witnessed by a person over the age of 18 years, not being a relative, who has known you for a minimum of 12 months and is an Australian citizen.

PART D: 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)	Medicare card (issued by the Health Insurance Commission)	Utilities bills e.g. telephone, electricity or gas bill
Australian passport	Centrelink card (issued by Centrelink)	Bank statements showing your residential address
	Department of Veterans' Affairs (DVA) card (issued by DVA)	Property rates notice
	Credit card or account card (issued by a financial institution in Australia)	Home insurance papers

I hereby declare that the statements made 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

Date

D	D	M	M	Y	Y

Signature of Witness

Full Name

Occupation

Address

Contact Telephone No

This form should be addressed to:

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

Telephone: (02) 8223 6600

Facsimile: (02) 8223 6699

Toll Free: 1800 550 027

Email: enquiries@ddb.nsw.gov.au

Web: www.ddb.nsw.gov.au



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