



Workers' Compensation Dust Diseases Board of NSW

Making A Difference®

FORM TWO
Application by Worker for Workers'
Compensation Entitlement

WORKERS' COMPENSATION (DUST DISEASES) ACT 1942

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

Ако вам је потребна помоћ тумача да попуните овај формулар, молимо вас да контактирате Workers' Compensation (Dust Diseases) Board (Комисију за утврђивање одштете због повреде на раду – Болести изазване прашином) на бесплатан број 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.

For Office Use Only

File No:

Date Entered:

D D M M Y Y Y Y



PERSONAL DETAILS

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. Your Full Name (Use BLOCK LETTERS)

Mr

Mrs

Miss

Ms

Family Name:

First Name:

Second Name(s):

2. Birth Details

Gender (please tick ✓)

Male

Female

Date of Birth:

D D M M Y Y Y Y

Country of Birth:

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

Street Number:

Street Name:

Suburb:

State:

Postcode:

Country:

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

Street Number:

Street Name:

Suburb:

State:

Postcode:

Country:

4. Contact Details

Home:

Business:

Mobile:

Fax:

(Please tick ✓ if you give your consent for us to contact you via email or fax)

Email:

5. Marital Status

Single

Married

Divorced

De facto

Widowed

Name of Partner (if applicable):

6. **Are you currently employed?**

Yes (please tick the appropriate box below) No- please proceed to question 7

If Yes, (Please tick ✓): Full-time Part-time Casual Self Employed

7. **Did you cease employment due to ill health? (Please tick ✓)** Yes No

Any other reason (Please provide details) _____

(a) On what date did you last work?

D	D	M	M	Y	Y	Y	Y

(b) Do you intend to work again? (Please tick ✓) Yes No

8. **Details of Current/Last employer?**

Employer's Name: _____

Street name: _____

Suburb: _____ State: _____ Postcode: _____

Country: _____ Telephone No: () _____

9. **If you are currently employed or had to leave your employment due to your dust related health condition please state your present or last gross weekly earnings (before tax and other deductions, eg union fees, garnishees, etc. Please state details of overtime, penalty rates, allowances, bonus, etc.)**

- Please attach a copy of your group certificate, letter from employer showing last date of duty and reason for leaving employment and an income tax return or pay slips as proof of weekly earnings. If you have an enterprise agreement, please provide a copy as proof of weekly earnings.
- If you were self employed please provide a letter from your accountant showing the date that you ceased work and your weekly income.

10. **Are you currently receiving compensation from any other source (e.g. a State WorkCover Authority, Comcare, overseas, etc) for an incapacity or disablement from any injury or disease?**

(Please tick ✓) Yes, give details below No

• If you have answered yes please state the disease/injury/condition you are being compensated for

Please attach copies of any relevant documents

11. Have you claimed compensation or do you intend to claim compensation from any other source (e.g. a State WorkCover Authority, Comcare, overseas, etc) for your dust disease other than by this application?

(Please tick ✓) Yes, give details below No Undecided

• Please contact the Dust Diseases Board within 7 days if you commence any compensation proceedings against another source at any time after you have lodged this application.

Please attach copies of any relevant documents

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

(Please tick ✓) Yes, give details below No Undecided

• Please contact the Dust Diseases Board within 7 days if you commence any compensation proceedings against another source at any time after you have lodged this application.

Please attach copies of any relevant documents

13. Do you have a spouse/partner?

(Please tick ✓) Yes, give details below No, go to question 17

(a) Please state your spouse/partner's full name: _____

(b) Please state your spouse/partner's date of birth?

D	D	M	M	Y	Y	Y	Y

(c) Please state date of marriage or date of commencement of defacto relationship?

D	D	M	M	Y	Y	Y	Y

• Spouse including married couple, defacto or same couple relationship.

14. **Is your spouse/partner currently employed?**

No Yes If Yes, (Please tick ✓): Full-time Part-time
 Casual Self Employed

Employers Name: _____

Street name: _____

Suburb: _____ State: _____ Postcode: _____

Country: _____ Telephone No: () _____

(a) What is his/her gross weekly wage? _____

Please attach a copy of your spouse/partner's group certificate, letter from employer, income tax return or payslips as proof of weekly earnings. If your spouse/partner has an enterprise agreement please attach a copy as proof of their weekly earnings. If your partner is self employed please provide a letter from their accountant detailing gross earnings and hours worked.

15. **Does your spouse/partner receive any type of pension, benefit or allowance (including any overseas payments)?**

(Please tick ✓) Yes, give details below No

(a) What is the type of pension, benefit or allowance? _____

(b) What is the fortnightly rate? _____

Please attach copies of any relevant documents

16. **Does your spouse/partner receive income from any other source such as investment, rental income etc.. (including any overseas incomes)?**

(Please tick ✓) Yes, give details below No

(a) Source of income: _____

(b) Amount: _____

(c) Frequency; Weekly Fortnightly Monthly Quarterly Annually

Please attach copies of any relevant documents

17. Please provide details of all dependent children including full time students aged between 16 and 21 years. Please complete for each dependent child.
 (NB: dependent child includes natural children, step children, foster children and adopted children)

DEPENDANT CHILDREN	Relationship to Applicant	Address	Details of educational institution if full-time student
Child One			
Family Name: _____	Applicant	Street: _____	Name of Institution: _____
First Name: _____	Deceased Worker	Suburb: _____	Street/PO Box: _____
Second Name: _____	Degree of Dependency	State: _____ Postcode: _____	Suburb: _____
Date of Birth: _____	YES NO	Phone No: _____	State: _____ Postcode: _____
<div style="display: flex; justify-content: space-between;"> DDMMYYYY </div>	Wholly: <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Tick box if same as applicant <input type="checkbox"/> Tick box if same as deceased worker's last known address	Phone No: _____
<div style="display: flex; justify-content: space-between;"> DDMMYYYY </div>	Partial: <input type="checkbox"/> <input type="checkbox"/>		Full time or part time student? _____
Child Two			
Family Name: _____	Applicant	Street: _____	Name of Institution: _____
First Name: _____	Deceased Worker	Suburb: _____	Street/PO Box: _____
Second Name: _____	Degree of Dependency	State: _____ Postcode: _____	Suburb: _____
Date of Birth: _____	YES NO	Phone No: _____	State: _____ Postcode: _____
<div style="display: flex; justify-content: space-between;"> DDMMYYYY </div>	Wholly: <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Tick box if same as applicant <input type="checkbox"/> Tick box if same as deceased worker's last known address	Phone No: _____
<div style="display: flex; justify-content: space-between;"> DDMMYYYY </div>	Partial: <input type="checkbox"/> <input type="checkbox"/>		Full time or part time student? _____
Date of Commencement of studies: _____			

DEPENDANT CHILDREN	Relationship to Applicant	Address	Details of educational institution if full-time student																			
Child Three																						
Family Name: _____	Applicant	Street: _____	Name of Institution: _____																			
First Name: _____	Deceased Worker	Suburb: _____	Street/PO Box: _____																			
Second Name: _____	Degree of Dependency YES NO	State: _____ Postcode: _____	Suburb: _____																			
Date of Birth: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>											D	D	M	M	Y	Y	Y	Y	Y	Wholly: <input type="checkbox"/>	Phone No: _____	State: _____ Postcode: _____
	D	D	M	M	Y	Y	Y	Y	Y													
Partial: <input type="checkbox"/>	<input type="checkbox"/> Tick box if same as applicant	Full time or part time student? _____	Phone No: _____																			
Child Four																						
Family Name: _____	Applicant	Street: _____	Name of Institution: _____																			
First Name: _____	Deceased Worker	Suburb: _____	Street/PO Box: _____																			
Second Name: _____	Degree of Dependency YES NO	State: _____ Postcode: _____	Suburb: _____																			
Date of Birth: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>											D	D	M	M	Y	Y	Y	Y	Y	Wholly: <input type="checkbox"/>	Phone No: _____	State: _____ Postcode: _____
	D	D	M	M	Y	Y	Y	Y	Y													
Partial: <input type="checkbox"/>	<input type="checkbox"/> Tick box if same as deceased worker's last known address	Full time or part time student? _____	Phone No: _____																			
Child Five																						
Family Name: _____	Applicant	Street: _____	Name of Institution: _____																			
First Name: _____	Deceased Worker	Suburb: _____	Street/PO Box: _____																			
Second Name: _____	Degree of Dependency YES NO	State: _____ Postcode: _____	Suburb: _____																			
Date of Birth: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>											D	D	M	M	Y	Y	Y	Y	Y	Wholly: <input type="checkbox"/>	Phone No: _____	State: _____ Postcode: _____
	D	D	M	M	Y	Y	Y	Y	Y													
Partial: <input type="checkbox"/>	<input type="checkbox"/> Tick box if same as deceased worker's last known address	Full time or part time student? _____	Phone No: _____																			

* NB:
Wholly Dependent
 Dependant who does not have their own income
Partially Dependent
 Dependant who receives their own 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.

FORM OF SPECIAL ENDORSEMENTS

1. If assistance is required in completing this form please complete either A. B. or C. of the following

- A.** The details in this application form were completed by me on behalf of the Applicant and the contents of the Application and the Dust Diseases Board's Privacy Disclosure Statement were read by me to the Applicant and the Applicant indicated his/her consent and the truth of the answers contained herein.

Signature of DDB Officer: _____

Print Name: _____

DDB Position: _____ Date:

D	D	M	M	Y	Y	Y	Y

- B.** The details in this application form were completed by me on behalf of the Applicant and the contents of the Application and the Dust Diseases Board's Privacy Disclosure Statement were read by me to the Applicant and the Applicant indicated his/her consent and the truth of the answers contained herein.

Signature: _____

Print Name: _____

Relationship to Applicant: _____ Date:

D	D	M	M	Y	Y	Y	Y

(e.g. Legal representative, spouse, partner, family member over the age of 18 years authorised by a Power of Attorney or appointed as Guardian)

- C.** I assisted in the completion of this application form by reading the questions to the Applicant in the _____ language and translated his/her responses to each question from the _____ language to the English language. The Applicant indicated his/her consent and the truth of the answers contained herein.

I also read the Dust Diseases Board's Privacy Disclosure Statement to the Applicant in the _____ language.

Signature of Interpreter/Translator: _____

Print Name: _____ Date:

D	D	M	M	Y	Y	Y	Y

2. Do you give authority for another person to provide information and/or make enquires on your behalf?

(Please tick ✓) Yes, give details below No

Name of Authorised Person: _____

Relationship to Applicant: _____

Address: _____

_____ Phone Number: _____

CHECKLIST OF INFORMATION / DOCUMENTS

- Attach a copy of your group certificate, letter from employer, income tax return, pay slips, enterprise agreement or letter from accountant if applicable. (Please refer to **Questions 6 – 9**)

- Attach copies of any relevant documents. (Please refer to **Question 10-11**)

- Attach a copy of your spouse / partner's group certificate, letter from employer, income tax return, payslips, enterprise agreement or letter from accountant if applicable.
(Please refer to **Question 14**)

- Attach copies of any relevant documents. (Please refer to **Question 15**)

- Attach copies of any relevant documents. (Please refer to **Question 15-16**)

- Ensure that you have read the Dust Diseases Board's Privacy Disclosure Statement before signing the Declaration.

DECLARATION BY APPLICANT

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.

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 regarding his/her industrial or medical history or dependents or other material matter 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, have read or have had read to me 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 medical examination and 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	Y	Y

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: ddb.nsw.gov.au

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Sydney NSW 2000

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