Form

Death claim form – dependant

Return to Work Act

This claim form is to claim for compensation following the work-related death of a worker under Northern Territory workers compensation legislation. A person claiming compensation or someone on their behalf (eg parent, guardian) may complete this form.

For help completing this form or for more information contact:

- The worker's employer (at the time of his or her death or the time the worker ceased work)
- NT WorkSafe Workers Rehabilitation and Compensation: Australia-wide toll free number 1800 250 713 or (08) 8999 5585 or email datantworksafe@nt.gov.au.
- The worker's union representative.

To make a claim you need to:

- Be a dependant of someone who died following a work related injury or disease.
- Carefully complete this form, either typing in the on-line form or clearly printing on a printed copy of the form. If there is insufficient space to answer a question, please attach additional notes or information.
- Give the completed claim form to the worker's employer within 6 months after the advice of the death has been received by the claimant (this time limit may be extended if it is found that the failure was occasioned by mistake, ignorance of a disease, absence from the Northern Territory or other reasonable cause). If you have difficulty giving this claim to the employer or the employer refuses to take receipt of the claim form, you can contact NT WorkSafe directly for advice and assistance.
- Keep a copy of the completed form and any attachments for your records.

Entitlements:

Entitlements for dependants* are determined in accordance with Northern Territory workers compensation legislation and may include:

- Payment or reimbursement of the reasonable costs of medical and like services received by the worker because of the work-related injury or disease leading to death.
- Funeral costs to the person liable to meet the expense (capped at a maximum amount).
- Family counselling.
- Expert financial advice.
- Lump sum payment of prescribed proportions to dependants (of an amount equal to 364 times average weekly earnings at the time the payment is made)
- Prescribed children's benefits (of an amount per week equal to 10% of average weekly earnings at the time the payment is made). If more than ten children the aggregate of all amounts paid shall not exceed 100% of average weekly earnings.
- Entitlements, including whether a person is a 'dependant' or 'non-dependant' family member, are determined by the insurer in the first instance. Any disputes to the determination are dealt with by an application to the Work Health Court.

*** Definition of dependant**

- Dependants of a deceased worker are the family and spouse of that worker who are partly or wholly dependent on the worker's earnings at the date of the worker's death.
- A spouse is the husband or wife of the deceased worker.
- 'Spouse' also includes de facto partners, and if the person is an aboriginal native, can include a partner according to the customs of the deceased worker's tribe or group.
- 'Family' can include any children or grandchildren of the deceased worker. This includes children born out of wedlock, and children who are not the deceased worker's natural offspring eg adopted children.
- Similarly, 'family' can also include any parent or grandparent of the deceased worker even though the deceased worker was born out of wedlock or was not the parent's natural offspring.
- If the person is an aboriginal native, family can include all persons who are members of the deceased worker's family according to customs of the deceased worker's tribe or group.

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This panel must be completed by the insurer	Insurer claim No
Date claim form received:	Work Health Authority Claim No

1. Deceased's personal details

Title:	Mr ☐	Mrs ☐	Ms ☐	Miss ☐			
Last, surname, family name:							
First or given name:							
Gender:	Male ☐	Female ☐					
Home address:							
Suburb:		State:		Postcode:			
Date of birth:		Date of death :					

2. Deceased's employment details

Please answer the following as best as you are able to. If possible contact the employer of the deceased to assist you.					
Employers business name:					
Employers trading name: (if different from above)					
Name of employer: (if known)					
Employers address:					
Suburb:		State:		Postcode:	
Employers work phone number:		Employers mobile number:			
Fax number:		Email address:			
What was the deceased's usual occupation at the time of injury or disease which led to death:					
Where did the deceased normally work:					
Location where the deceased did majority of work (if multiple locations):					
Address where the deceased did majority of work:					
Suburb:		State:		Postcode:	
Did the deceased have any other employment at the time of the injury or disease causing or contributing to the death:	Yes ☐	No ☐			
If Yes, please provide or attach information about the name and address of any other employer of the deceased::					
Name of employer:					
Employers address:					
Suburb:		State:		Postcode:	
Was the injury or disease reported to the employer:	Yes ☐	No ☐			
If **no**, reason not reported:					
If **yes**: Date		Time	am ☐	pm ☐	
Name of person reported to:					
Persons position in the company:					
Was the deceased off work for any period prior to death which may have been due to this injury or disease	Yes ☐	No ☐			
If **yes**, period off work from		to			
Did the deceased receive any compensation payments for this period	Yes ☐	No ☐			
If **yes**, amount received	**$**				

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3. Injury or disease and death circumstances

Please refer to the front page of this form about obtaining assistance with these questions.

Has a claim for compensation previously been made by the deceased for the injury or disease causing or contributing to their death: Yes ☐ No ☐

If **yes**, please provide claim number/s and details:

What was the injury or disease that caused or contributed to the deceased's death and the body part/s affected (eg crush injuries to upper body, broken leg, lung cancer or mesotheliomas caused by asbestos)

Did the injury or disease causing or contributing to the deceased's death occur over a period of time:

Period of time (months/years): and the injury or disease was first noticed on:

Please attach a copy of the deceased's full or interim death certificate. You can obtain a copy of the death certificate from Births, Deaths and Marriages NT or the equivalent State or Territory registry. If the death has not yet been registered and you do not yet have a copy of the death certificate at this time, please answer the following questions as best as possible:

What was the medical reason given for the cause of the deceased's death (eg multiple injuries due to motor vehicle collision, electrocution, melioidosis, lung cancer or mesotheliomas)

What is the date and time (if known) of the deceased's death:

Date: Time: am ☐ pm ☐

Where did the death occur::

Where did the injury or disease that caused or contributed to the deceased's death occur - if applicable, please provide the street address of the workplace or work site and the exact location where the injury or disease occurred (eg boiler room) if known.:

Location:

Address:

Suburb: State: Postcode:

Did the injury or disease occur at the employer's workplace or work site: Yes ☐ No ☐

If no, please provide details about which person or organisation was responsible for the workplace or work site if applicable or the street address where the injury or disease occurred:

Responsible person or organisation:

Address:

Suburb: State: Postcode:

To the best of your ability, please provide as much detail as possible about what the deceased was doing when the injury or disease that caused or contributed to the death occurred:

Please indicate which of the following circumstances applied when the injury or disease causing or contributing to the deceased's death occurred:

A	Deceased was working at the usual workplace or work site	☐
B	Deceased was working away from the workplace or work site	☐
C	During a meal-break or authorised recess at work	☐
D	Deceased was travelling to or from work	☐
	Other. Please specify below the deceased's activity such as 'travelling to / attendance at training school', 'travelling to / attendance at medical centre' or 'travelling between employer's premises' if the deceased had more than one job	☐

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4. Medical information

Did the deceased receive any medical treatment following the injury or disease:	Yes ☐	No ☐			
If **yes**, give full name and address of treating professional:					
Professional name:					
Address:					
Suburb:		State:		Postcode:	
Dates treated:	from		to		
Prior to death was the deceased admitted to a hospital or medical centre:	Yes ☐	No ☐			
If **yes**, give full name and address of hospital or medical centre:					
Hospital or medical centre name:					
Address:					
Suburb:		State:		Postcode:	
Period of time in hospital or medical centre:	from		to		
Had the deceased suffered from a similar injury or disease before:	Yes ☐	No ☐			
If **yes**, give full name and address of medical practitioner who treated the deceased:					
Name of medical professional:					
Address:					
Suburb:		State:		Postcode:	
Type of injury or disease treated:					
When did the injury or disease occur:					

5. Witnesses

Are you aware of any witness to the occurrence of the injury or disease:	Yes ☐	No ☐			
If yes, please provide name and contact details of any person who saw what happened:					
Name:					
Address:					
Suburb:		State:		Postcode:	
Home number:		Work number:			
Mobile number:		Email address:			

6. About the deceased's dependants

Please provide the following details about all the dependants of the deceased. If there is not enough space, write the details on a separate piece of paper and attach it to this form.					
Surname or family name:					
First or given name:					
Home address:					
Suburb:		State:		Postcode:	
Relationship to deceased (wife/husband/son/daughter etc):					
Date of birth of this dependant:					
Is this dependant a student	Yes ☐	No ☐		Full time: ☐	Part time: ☐
Surname or family name:					
First or given name:					
Home address:					
Suburb:		State:		Postcode:	
Relationship to deceased (wife/husband/son/daughter etc):					
Date of birth of this dependant:					
Is this dependant a student	Yes ☐	No ☐		Full time: ☐	Part time: ☐

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Surname or family name:	
First or given name:	
Home address:	
Suburb:	State: Postcode:
Relationship to deceased (wife/husband/son/daughter etc):	
Date of birth of this dependant:	
Is this dependant a student	Yes ☐ No ☐ Full time: ☐ Part time: ☐
Surname or family name:	
First or given name:	
Home address:	
Suburb:	State: Postcode:
Relationship to deceased (wife/husband/son/daughter etc):	
Date of birth of this dependant:	
Is this dependant a student	Yes ☐ No ☐ Full time: ☐ Part time: ☐
Surname or family name:	
First or given name:	
Home address:	
Suburb:	State: Postcode:
Relationship to deceased (wife/husband/son/daughter etc):	
Date of birth of this dependant:	
Is this dependant a student	Yes ☐ No ☐ Full time: ☐ Part time: ☐
Surname or family name:	
First or given name:	
Home address:	
Suburb:	State: Postcode:
Relationship to deceased (wife/husband/son/daughter etc):	
Date of birth of this dependant:	
Is this dependant a student	Yes ☐ No ☐ Full time: ☐ Part time: ☐
Surname or family name:	
First or given name:	
Home address:	
Suburb:	State: Postcode:
Relationship to deceased (wife/husband/son/daughter etc):	
Date of birth of this dependant:	
Is this dependant a student	Yes ☐ No ☐ Full time: ☐ Part time: ☐

7. Declaration

I declare that all the information I have shown in this form is true and correct to my knowledge and I have told you everything I know about the circumstances relating to the work related injury or disease which led to the death of the deceased.

Name of person completing this form:	
Relationship of person completing this form to the deceased :	
Home address of person completing this form:	
Suburb:	State: Postcode:
Signature	Date:
Date completed form provided to the deceased employer or the insurer:	