Death claim form – employers report

*Return to Work Act*

# To the employer

* Fill in this ‘death claim form – employers report’ if you have received a ‘death claim form – dependant’ following the death of a worker.
* Send the original of this report together with the original of the ‘death claim form – dependant’ to your insurance company immediately.
* Keep a copy of your report and the ‘death claim form – dependant’ for your records.

# Help

You can get help and further information from:

NT WorkSafe

First Floor Darwin Plaza Building

41 Smith Street, The Mall

Darwin NT 0800

Australia-wide toll free telephone number: 1800 250 713

Email: datantworksafe@nt.gov.au

Website: [www.worksafe.nt.gov.au](http://www.worksafe.nt.gov.au)

The form starts on page 2.

| **Death claim form – employers report** |
| --- |
| **This panel must be completed by the insurer** | **Insurer claim No** |  |
| Date claim form received: |  | **Work Health Authority Claim No** |  |
| **1.** | **Notifiable incident**  |
| The death of a person is required to be notified to NT WorkSafe. Was this death notified | Yes | **[ ]**  | No | **[ ]**  |
| If **yes**, date of notification: |  | Reference number given by NT WorkSafe: |  |
| The *Work Health and Safety (National Uniform Legislation) Act* (WHS Act) requires the regulator (NT WorkSafe) to be notified of certain ‘notifiable incidents’. In summary Part 3 of the WHS Act requires:* Immediate notification of a ‘notifiable incident’ to the regulator after becoming aware of it by calling 1800 019 115 (this number can be used 24 hours a day)
* If the regulator asks, written notification must be given within 48 hours of the request. This must be provided in the approved ‘Incident Notification Form’ available on the NT WorkSafe website.
* Preservation of the incident site until an inspector arrives or directs otherwise. This is subject to some exceptions.

Failing to notify is a criminal offence and penalties apply. Further information on what is a notifiable incident can be found in information bulletin ‘Notification of Incidents’ available on the NT WorkSafe website. |
| **2.** | **Employer details** |
| Business entity name: |  |
| Business trading name: (if different from above) |  |
| Australian Business number: (ABN) |  |
| Australian Company Number: if applicable |  |
| Address for correspondence: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Work number: |  | Mobile number: |  |
| Fax number: |  | Email address: |  |
| Name of person who can be contacted in relation to this claim: |  |
| Position in the business: |  |
| **3.** | **Workers’ compensation insurance policy information** |
| What is your workers compensation insurers name: |  |
| What is the policy number: |  | What is the expiry date on policy: |  |
| **4.** | **About the deceased worker** |
| Title: | Mr | **[ ]**  | Mrs | **[ ]**  | Ms | **[ ]**  | Miss | **[ ]**  |
| Last, surname, family name: |  |
| First or given name: |  |
| Gender: | Male | **[ ]**  | Female | **[ ]**  | Date of birth: |  | Age: |  |
| Home address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Where within your establishment did the worker normally work: (your answer here must tell us the actual section and address of the workplace location where the worker did the majority of his or her work) |
| Section where worker normally worked: |  |
| Normally based location address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| How many people are employed at this particular location: at the normally based location address, at the present time |
| 1 to 4 | **[ ]**  | 5 to 9 | **[ ]**  | 10 to 19 | **[ ]**  | 20 to 49 | **[ ]**  |
| 50 to 99 | **[ ]**  | 100 to 199 | **[ ]**  | 200 to 499 | **[ ]**  | 500 plus | **[ ]**  |
| When was the worker first employed by you: |  |
| When did the worker stop work following the injury or disease which led to death |
| Date |  | Time |  | am | **[ ]**  | pm | **[ ]**  |
| Occupation at time of injury or death: | Direct employee | **[ ]**  | Working director | **[ ]**  |
| Employee of contractor | **[ ]**  | Contractor | **[ ]**  | Sub-contractor | **[ ]**  |
| Visa worker | **[ ]**  | Other (please specify) |  |
| What is the type of industry at the establishment where the worker normally worked: you must state the main type of activity, business or service you provide in which the injured worker was involved. You do not put the actual occupation of a worker, for example, if you are a gold mining company and the injured worker is a driver, put down gold mining |
|  |
| **5.** | **About this claim** |
| Is this claim about a death related to disease | Yes | **[ ]**  | No | **[ ]**  |
| If **yes** go to number 6 ‘About the deceased workers disease’ |
| If **no** go to number 7 ‘About the deceased workers injury’ |
| **6.** | **About the deceased workers disease** |
| Main address where disease contracted |  |
| Suburb: |  | State: |  | Postcode: |  |
| Please describe the events which led to the disease and subsequent death including the main cause |
|  |
| **7.** | **About the deceased workers injury** |
| Where did the injury happen |
| A | While working at usual workplace | [ ]  |
| B | While working elsewhere | **[ ]**  |
| C | While having a break | **[ ]**  |
| D | Travelling to or from work | **[ ]**  |
|  | Other. Please specify 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. |  |
| Exact location or address where the injury happened |  |
| Suburb: |  | State: |  | Postcode: |  |
| Date of injury |  | Time of injury |  | am | **[ ]**  | pm | **[ ]**  |
| Please describe all the events which led to the injury, what the worker was doing at the time of the injury and how the injury happened |
|  |
| **8.** | **About the incident** |
| Was there a major event where more than one person was injured or killed eg fire, explosion | Yes | **[ ]**  | No | **[ ]**  |
| Date of incident |  | Time of incident |  | am | **[ ]**  | pm | **[ ]**  |
| Address where incident occurred: |  |
| Suburb: |  | State: |  | Postcode: |  |
| What was the deceased doing at the time - how did the incident happen or what caused the disease. Include the object or substances that caused the incident. For example grinder, saw or drill. **Note**: if insufficient space, attach full details. |
|  |
| **9.** | **Witnesses** |
| Did anyone see what happened to the deceased worker: | Yes | **[ ]**  | No | **[ ]**  |
| Name and contact details of any person who saw what happened |
| Name: |  |
| Address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Home number: |  | Work number: |  |
| Mobile number: |  | Email address: |  |
| Name: |  |
| Address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Home number: |  | Work number: |  |
| Mobile number: |  | Email address: |  |
| Was the injury or disease reported to you as 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 worker off work for any period prior to death which may be due to this injury or disease | Yes | **[ ]**  | No | **[ ]**  |
| If **yes**, period off work | from |  | to |  |
| Did the deceased worker receive any compensation payments for this period | Yes | **[ ]**  | No | **[ ]**  |
| If **yes**, amount received | **$** |
| **10.** | **Declaration** |
| I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that making a misleading statement or giving a document that contains misleading information is an offence. |
| Signature |  | Date: |  |
| Name: of person who has filled in this form |  |
| Position in the business: |  |
| Date this report and the ‘death claim form – dependants’ forwarded to your insurer: |  |