LGW
LOCAL GOVERNMENT WORKCARE

Queensland Local Government Workcare Scheme
Local Government House 25 Evelyn St Newstead Qld 4006

PO Box 2321 Fortitude Valley BC Qld 4006
Telephone: (07) 3000 5555 Facsimile: (07) 3000 5560

Application for Compensation – Fatal

The Application for Compensation is an approved form pursuant to section 132 of the *Workers' Compensation and Rehabilitation Act 2003*.

Applicant's Details

1 Surname or family name

2 Given or first names

3 Relationship to deceased worker

4 Present residential address

Street

Suburb/Town

Postcode | Phone

5 Postal address (if same as residential address, write 'as above')

Street

Suburb/Town

Postcode

Deceased Worker's Details

6 Surname or family name

7 Given or first names

8 Gender

☐ **Male** ☐ **Female**

9 Date of birth

10 Residential address (immediately prior to death)

Street

Suburb/Town

Postcode

11 Deceased worker's dependants (provide full details)

Name of dependant

Date of Birth

Residential address

Occupation

Relationship to deceased

11 Deceased worker's dependants (continued)

Name of dependant

Date of Birth

Residential address

Occupation

Relationship to deceased

Name of dependant

Date of Birth

Residential address

Occupation

Relationship to deceased

Name of dependant

Date of Birth

Residential address

Occupation

Relationship to deceased

12 Is there any possibility of a posthumous child?

☐ **Yes** (see below) ☐ **No**

Expected Date of Birth

13 Are you aware of any other person who may have been dependent on the deceased at the time of death?

☐ **Yes** (detail below) ☐ **No**

Details of Injury

14 **Where did the injury happen?**
(e.g. workshop floor, Gant Street, Oakey)

Place

Street

Suburb/Town

Postcode

15 **When did the injury happen?**

Day Time Date

16 **Date of death**

Day Date

17 **Cause of death**

18 **Explain what the deceased was doing at the time the injury happened and how it happened**

19 **Was any other person or thing involved?**

☐ **Yes** (detail below) ☐ **No**

20 **Was a motor vehicle/s involved?**

☐ **Yes** (detail below) ☐ **No**

Registration Number/s

Owner/s of Vehicle/s

Applicant's Statement

I acknowledge that it is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading.

I hereby authorise any doctor, health authority, allied health provider, rehabilitation provider or other insurer to disclose to Queensland Local Government Workcare (LGW) any information regarding the deceased worker's medical history relevant to this application.

Signature of applicant **Date**

Signature of witness **Date**

Employer's Report

The Employer's Report is not part of the approved form.

1 **Employer name**

2 **Workplace Accreditation Number** (for this worker)

3 **Business Workplace Registration Number** (for this worker)

Employment Particulars

4 **Worker's payroll number**

5 **Worker's occupation**

6 **Period of employment with your Council**

From To

7 **Employment type**

☐ Full-time ☐ Part-time ☐ Casual

☐ Other (describe below)

8 **Was this worker employed under a contract of service?**

☐ **Yes** ☐ **No**

9 **State total gross earning for 3 year period prior to the injury or, if employed less than 3 years, for the period of employment**

$

10 **Are you satisfied that the injury/condition happened in the manner reported?**

☐ **Yes** ☐ **No** (attach details)

Employer's Authorised Officer

Officer's signature

Print name

Position held

Date