



COAL MINES INSURANCE PTY LIMITED
Employee's Compensation Claim Form To Be Given To Your Employer
(Form M)

Employer's name

Name of mine/establishment

ABOUT THE WORKER

Surname First names

Home address Post code

Home / Mobile No. Date of birth/...../..... Sex: male/female (please circle)

Occupation No. of years in industry

Tax file No.

INJURY DETAILS

Date of incident/...../..... Time of incidentam/pm

Time shift commenced on day of incident am/pm Date and time incident report/...../.....am/pm

To whom was the incident reported (name and position)

Did you cease work as a result of injury? Yes No

If yes, date and time work ceased/...../.....am/pm

What body parts were affected? (eg left upper arm, lower back)

What kind of injuries did you suffer? (eg fracture)

Was the part affected or injured by this accident normal before this accident? Yes No

If no, please give details

Name of your treating doctor (if applicable)

WorkCover medical certificate attached Yes No

WHAT HAPPENED

Explain fully how the injury was sustained and what you were doing at the time

.....

.....

.....

Place where you were when injury occurred

Name the type of tool or machine being used

Were there any witnesses to the incident? Yes No If yes, please provide witnesses names and contact details

.....

DEPENDANTS

If compensation is claimed for dependants, this list must be completed. Full and accurate information regarding dependants is required. The persons listed are totally or mainly dependent on the claimant for support. If dependants receive no income write "NIL".

Surname	Given Names	Relationship to Claimant	Date of Birth	Present Address	Weekly Income	Employer's Name
.....
.....
.....
.....
.....

N.B. For Journey Injuries – a separate "journey accident" claim form must be completed in addition to this claim form.

OTHER SIMILAR INJURIES

Have you previously suffered any similar related injuries or conditions? Yes No

If yes, give details of how the injury occurred

.....

Name of employer (if applicable)

Date of injury(ies)/...../.....

OTHER CURRENT EMPLOYERS

Do you have any other employment including a business or self-employment? Yes No If yes, provide the following details:

Full name of employer:

Employer's business address

INJURED WORKER'S DECLARATION

I declare that the particulars are true and correct, that I have not withheld any information, and that the injuries I have received were caused in the manner stated above, and in no other way whatsoever.

I consent to CMI and its appointed service providers collecting using and disclosing my personal information in accordance with its privacy policy and in particular collecting personal information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true.

I consent to CMI disclosing my personal information to medical practitioners, rehabilitation providers, legal practitioners and other experts or consultants for the purposes of assessing and managing my claim. I also consent to CMI disclosing my personal details to the WorkCover Authority which is authorised to use this information to fulfil its functions under the NSW workers' compensation legislation.

I understand that while I am in receipt of weekly compensation benefits, I am required to notify CMI at once if any of the following occur:

1. I commence employment with another employer.
2. I commence my own business.
3. There is any change in my employment that affects my earnings.
4. Any of the abovementioned dependants cease to be dependent upon me.
5. If I change my address.

I acknowledge my obligation under Section 57 of the Workers' Compensation Act 1987.

I understand that if any information I have given is untrue, that my claims may be denied and that I may be prosecuted.

(Note: a photocopy of this authority shall be as valid as original)

Signature of injured worker Date/...../.....

Date received by employer/...../.....

Privacy Statement: Information of opinions on this form that could reasonably identify you to another person are considered to be "personal information" under privacy legislation introduced in December 2001. CMI will only use or disclose your personal information for purposes that would reasonably be expected during the claim process, eg. Sharing your information with other services providers, medical practitioners involved in your claim. CMI will seek your permission before using your personal information for any other purposes. If you would like any further information in relation to CMI's privacy policy or if you have any concerns about how CMI is managing your personal information, please contact the privacy officer by e-mail: pco@coalservices.com.au or telephone (02) 8270 3200.