

Application for review by the insurer

Effective 1 January 2019

You (the worker) may use and send this form to the insurer if you want the insurer to review a work capacity decision, or a decision to dispute liability in respect of a workers compensation claim or any aspect of a claim, made on or after 1 January 2019.

If you require an interpreter, call 13 14 50 to arrange a free interpreting service.

Information for workers

If you need help to request a review, please contact the insurer in the first instance or alternatively the Workers Compensation Independent Review Office (WIRO) on 13 94 76.

Stay of a work capacity decision

When you lodge a dispute with the Workers Compensation Commission (WCC) before the date the decision takes effect, as outlined in the work capacity decision notice, your weekly payments will not change until the WCC determines the dispute. The insurer will have explained how a stay may apply to your circumstances.

Internal review of an insurer decision

The review will be conducted by the insurer but it will be carried out by a different staff member from the one who made the original decision. Once completed, you will receive written notification detailing the review decision and reason. The insurer is required to complete the review and notify you of the outcome within 14 days from the date of your application. You may lodge a dispute with the WCC at any time and do not need to wait for the review to be completed by the insurer.

You can get advice from your union, a lawyer or WIRO if you are unsure about what the decision notice means, or would like to challenge (dispute) the decision, at any time. WIRO has a list of approved lawyers who can give advice at no cost to you. The list is available on the WIRO website www.wiro.nsw.gov.au, or call WIRO on 13 94 76.

1. Insurer Details Send to the insurer after receiving a decision note

Insurer

Insurer contact

Contact details

2. Your details

Given name(s)

Surname

Date of birth (DD/MM/YYYY)

Claim number(s)

Date of injury (DD/MM/YYYY)

Telephone

Email

How would you prefer to be notified of the review decision ?

Email

Post

3. Identify the decision(s) you would like the insurer to review

What was the date of the decision? (DD/MM/YYYY)

Select what you wish to have reviewed:

a work capacity decision a decision to dispute liability of a claim or any aspect of a claim

4. Outline the reason and why you believe the insurer decision should be different

5. Attach any information and evidence to support your application

List any attachments here

6. Worker declaration

I (print name)

have read the information provided in this form. I declare that the information I have 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 false or misleading claim or false or misleading statement in support of the claim is punishable by law and that I may be prosecuted.

Signature of worker

Date (DD/MM/YYYY)

Information about privacy

By completing and submitting this form, you are consenting to the collection by SIRA and the insurer of any personal and health information contained in the form and in any supporting documents. Both SIRA and the insurer may use this information during dealing with your application, and any subsequent applications you may make.

By completing this form, you are also consenting to your personal and health information being used by SIRA, and disclosed by SIRA to a third party, for administrative purposes including monitoring and reviewing the workers compensation system.

SIRA and the insurer are required to comply with the *Privacy and Personal Information Protection Act 1998* and *Health Records and Information Privacy Act 2002* when collecting, using or disclosing any of your personal or health information. You have the right to access your personal or health information held by SIRA or insurer, to be provided copies of that information, and to correct any inaccuracies in that information.