SAVE AS PRINT

NSW GOVERNMENT | WorkCover

Work capacity – application for internal review by insurer

This is the 'form approved by the Authority', referred to in section 44(2) of the *Workers Compensation Act 1987* (WC Act), for applications by a worker under s.44(1)(a) to an insurer for internal review of a work capacity decision by the insurer.

What is this form for?

Complete this form if you want the insurer managing your workers compensation claim to review a work capacity decision they have made.

Attach any supporting information that the insurer does not have. You can include more than one work capacity decision on the form. Frivolous and vexatious applications may be rejected.

Where do I send the form?

Send this form to the insurer within 30 days of receiving your work capacity decision notice. The decision will remain in force while the review is being undertaken.

What happens next?

The insurer will contact you within seven days of receiving this form, to inform you of the internal review procedures.

The review will be conducted by someone who was not involved in your original work capacity decision.

On completion of the review, you will receive a written response from the insurer with their decision and reasons.

Is an interpreter available?

Call **13 14 50** to arrange a free interpreting service.

Further information

The full set of rules and requirements of an internal review are outlined in section 44 of the WC Act, titled 'Review of work capacity decisions', and in division 2 of the 'Review guidelines', titled 'Internal reviews by insurers'.

These are available at **workcover.nsw.gov.au** or by calling WorkCover NSW on **13 10 50**.

1. WORKER'S DETAILS

Worker's name (first name then surname)

Claim number

Date of birth (DD/MM/YYYY) / /

2. WHICH WORK CAPACITY DECISION(S) DO YOU WISH TO HAVE INTERNALLY REVIEWED?

(Include the date of the decision that is on the insurer's work capacity decision notice.)

WORK SAFE HOME SAFE

3. HOW DO YOU THINK THE WORK CAPACITY DECISION(S) SHOULD BE CHANGED?
(Tell us what you want.)

4. WHY SHOULD THE WORK CAPACITY DECISION(S) BE CHANGED?
(Explain your reasons for opposing the work capacity decision(s). You can refer to and attach new information. Use more than one page if needed.)

5. SIGN HERE

Signature

Date (DD/MM/YYYY)

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WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | WorkCover Assistance Service **13 10 50**
Website **workcover.nsw.gov.au**

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