Australian Government

Department of Veterans' Affairs

Claim for Liability and/or Reassessment of Compensation

For use by serving and former members of the Australian Defence Force including Reserve Forces and cadets

Complete this form if you are claiming:

- acceptance of liability for injury or disease arising from service on or after 1 July 2004
- reassessment of compensation payable under the *Military Rehabilitation and Compensation Act 2004* (MRCA).

This form asks about

- your **personal** details
- your **injury** or **disease**.

Completing this form

Please **tick** the appropriate boxes and answer all questions.

Proof of identity

You will need to provide proof of your identity before the finalisation of your claim if you have not provided this before. The Department of Veterans' Affairs (DVA) will provide you with information on what forms of identity you will need to provide.

Assistance from service and ex-service organisations

You are strongly encouraged to seek assistance from a service or ex-service organisation of your choice in lodging this claim. Contact telephone numbers for these organisations can be found in local telephone directories or by contacting the DVA office in your State.

Assistance from Veterans' Affairs

DVA staff can also help you to complete this form.

The basis for decisions

The decision on whether your injury or disease is service-related is based on up-to-date medical and scientific evidence. This information is detailed in the Repatriation Medical Authority's Statements of Principles.

If your claim is for a condition not included in the Statements of Principles, it will be determined based on the best scientific and medical evidence available.

NOTE: To prevent delays in processing your claim, please have each claimed condition diagnosed and the details provided on a separate Injury or Disease Details Sheet.

Privacy Notice

The information provided on this form, and on any additional DVA forms you complete in relation to this claim, is required to assess your eligibility for benefits under one or more of the following applicable Acts: *Veterans' Entitlements Act 1986* (VEA), *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and MRCA. If the information you provide is used to assess your eligibility under one Act, it will not be used for the purpose of another Act unless authorised by law or you give a separate consent. Any information you provide on this form, or any other form relevant to this claim, may be disclosed to the following agencies and bodies for their lawful purposes:

- the Department of Defence;
- Centrelink;
- the Australian Taxation Office;
- the Child Support Agency;
- Medicare Australia;
- the legal representatives of the Department of Defence in relation to any common law (third party) damages action;
- ComSuper (regarding any Commonwealth superannuation entitlements you may have);
- Commonwealth, State and Territory workers' compensation authorities in relation to a similar injury or medical condition;
- doctors, hospitals and other health care professionals who have provided you with treatment or who are requested to assist in the investigation of your claim; and
- your current and/or previous employer(s).

You must tell DVA if any of the details you give in this form change.

If you need more information please contact DVA:

National Toll Free Number

1300 550 461

Internet

http://www.mrcs.gov.au

Addresses

By mail
Department of Veterans' Affairs
GPO Box 9998
in your Capital City (or in Townsville, QLD)

In person - contact 1300 550 461 for the address of the nearest office

You can complete this form on-screen and save the form OR print form and write in block letters with a blue or black pen (not pencil). Please tick/complete ALL appropriate boxes. You MUST print and then sign this form (digital signatures are not acceptable).

PART A — Representative details

1. Do you wish to nominate a representative or organisation to act for you in matters related to this claim?

No ☐ ▶ Please go to **PART B**

Yes ☐ ▶ Full name of nominated representative

Organisation *(if applicable)*

Is the representative trained under the Training and Information Program (TIP)?

No ☐

Yes ☐ ▶ To what level?

Address

Telephone

Home

Work

Mobile

Facsimile *(if applicable)*

E-mail address (if applicable)

The nominated representative must also sign this form at Question 26 on page 7

PART B — Personal details

2. Veterans' Affairs File No. *(if known)*

3. Title *(Mr, Mrs, Ms, Dr, etc.)*

4. Surname

5. Given name(s)

6. Previous name *(if applicable)*

7. Sex — Male ☐ Female ☐

8. Date of birth

9. Residential address

10. Postal address *(if same as residential, write 'AS ABOVE')*

11. Telephone numbers

Work

Home

Mobile

E-mail

12. Next-of-kin's name

Relationship to veteran/member

Next-of-kin's address

13. Next-of-kin's telephone numbers

Work

Home

Mobile

E-mail

PART C Service details

14. Please indicate if you are a:
(tick any which apply)

Serving member ☐ Former member ☐ Reservist ☐ Cadet ☐

Other ☐ ▶ Please specify

15. Please provide known details of your service in the Australian Defence Force

Service No/PMKeys No.	Arm of the services	Unit *(if still serving)*	Enlistment and discharge dates	Rank and Pay Group *(at discharge if discharged or currently if still serving)*
			to	
			to	
			to	
			to	
			to	
			to	

If you have other periods of service in the Australian Defence Force, please attach further details.

PART D — About your injury or disease

Tick the box or boxes that apply

- [ ] Claim for acceptance of liability for service related injuries or diseases that have not yet been accepted.
- [ ] Reassessment of previously accepted injuries or diseases.

16. List all the injuries or diseases you are now claiming or previously accepted injuries or diseases which have become worse.
Please attach a separate sheet if you wish to claim more than six conditions, or if more than six conditions have become worse.

1.	2.
3.	4.
5.	6.

Please complete and attach a separate **Injury or Disease Details Sheet (D2049)** for **every** injury or disease you are now claiming, please download as necessary or ask DVA for extra copies.

Please attach supporting medical and service information as indicated on the **Injury or Disease Details Sheet**.

17. Have the injuries or diseases you are now claiming affected your employment/performance of duties in the ADF or your ability to seek employment at any time?

No [ ]

Yes [ ] ▶ Please give details

If insufficient space, please attach a separate sheet

PART E — Current General Practitioner or Medical Officer

18. General Practitioner's or Medical Officer's name

19. Address

20. Telephone number

PART F — About the benefits you are seeking

21. If it is determined that there is liability to pay you compensation, what benefits are you seeking?
The person handling your claim will conduct a needs assessment to determine all your requirements for benefits under the MRCA.

- [ ] Permanent impairment compensation (for permanent physical or psychological disability)
- [ ] Incapacity payments (to replace income lost due to incapacity for service or work)
- [ ] Treatment
- [ ] Rehabilitation
- [ ] Attendant care services
- [ ] Household care services
- [ ] Vehicles modifications
- [ ] Don't know, please contact me

PART G — Payments other than MRCA payments

DVA PAYMENTS

22. Do you currently receive compensation or a pension from DVA?

No ☐
Yes ☐ ▶ Name of payment (e.g. disability pension, MCRS payments)

COMMON LAW DAMAGES

23. Have you claimed, or do you intend to claim common law damages against the Commonwealth or a third party in relation to any of the claimed injuries or diseases?

You must notify DVA in writing of the claim as soon as practicable but no later than 7 days after the day on which you make the claim. You must also notify DVA in writing within 28 days of recovering any damages.

No ☐
Yes ☐ ▶ Please give details - including Australian Government Department or third party name.

Nature of injury or disease	Name of compensation provider	Date of claim	Reference number

PAYMENTS FROM AGENCIES OTHER THAN DVA FOR CLAIMED INJURIES OR DISEASES

24. Are you already receiving, have you previously received or have you applied for, any payments in relation to any of the claimed injuries or diseases?

If you lodge a claim for any other pension, benefit or allowance while this claim is being processed or after liability is accepted, you MUST advise DVA.

No ☐
Yes ☐ ▶ Please give details

Type of income	Reference number	Type of payment	Conditions
Centrelink benefits			
ComSuper benefits - including DFRDB or MSBS			
COMCARE			

Other *(please give details)*

Type of benefit or pension	Name and address of source	Date of claim	Reference number *(if known)*

PART H Authorisation

25. Authorisation

This authorisation must be signed by you or your legal representative, if you cannot sign yourself.

I authorise the Department of Veterans' Affairs to obtain medical/psychological, clinical, employment or other information about me from Service Health Centres, medical practitioners, hospitals, clinics, insurance companies, Australian Government Departments or Agencies, or other organisations in relation to this claim or its review.

I agree that the Department of Veterans' Affairs may disclose personal information about me to other Agencies and bodies, where the Department of Veterans' Affairs or those other Agencies or bodies have a legitimate interest in such personal information.

I authorise the representative or organisation nominated in **PART A** (if any) to act for me in respect of this claim and any review of a decision relating to this claim.

This authorisation will continue until I:

- revoke this authorisation; or
- nominate another representative or organisation to act for me.

Claimant's full name (please print)

Claimant's/legal representative's signature

Date

The legal representative must also complete **PART J**.

26. Representative's signature

This part is to be signed by the representative who completed the Representative details in **PART A**. The signature indicates that they have assisted the claimant to complete this claim form and that all the information contained accurately reflects the claimant's statements and intentions.

Representative's signature

Date

PART I — Declaration

27. Declaration

This declaration must be signed by you or your legal representative if you cannot sign yourself.

I declare that:

- the details I have given on this form and on any attachments are true and accurate.
- I am aware that I must advise the Department of Veterans' Affairs immediately if I engage in any employment (whether paid or unpaid) or if I engage in running a business in my own right or as a partner during any period when I am medically certified to be unfit for work due to the injury, disease or illness to which this claim for compensation relates.
- I am aware that I must advise the Department of Veterans' Affairs immediately if my injury or illness improves during any period of certified incapacity for work sufficiently to allow me to return to work.
- I am aware that I must advise the Department of Veterans' Affairs if I receive any monies by way of third party damages in relation to the injury, disease or illness which is the subject of this claim for compensation.
- I am aware that I must advise the Department of Veterans' Affairs if I lodge a claim for any other pension, benefit or allowance while this claim is being processed.
- I am aware that any compensation monies which I may be paid as a result of any false or misleading claim or statement will be recovered by the Department of Veterans' Affairs.
- I am aware that a copy of this claim form may be sent to the Department of Defence.
- I am aware that there are penalties for making false statements.

Claimant's full name (please print)

Claimant's/legal representative's signature

Date

The legal representative must also complete **PART J**.

PART J — Legal representative's authority to act

28. Authority to act on behalf of the claimant (if the claimant is unable to sign due to physical or mental incapacity or is under a legal disability).

Details of the person who is legally authorised to act on behalf of the claimant who is unable to sign this claim.

Please attach a certified copy of the Enduring Power of Attorney, guardianship papers or other authorisation to act on the claimant's behalf.

Full name

Address

Telephone

Home

Work

Mobile

Signature of legal representative

Date

Please also sign **PART H** on page 7 and **PART I** above.