IMPORTANT

Australian Government

Department of Veterans' Affairs

DVA Rehabilitation & Compensation Claim Checklist

This checklist will help you make sure you haven't missed anything before you submit your claim:

Claim form relevant to your service dates and date of injury:

☐ MRCA: Claim for Liability and/or Reassessment of Compensation (D2051)

☐ Injury or Disease Details Sheet at the end of this form completed and signed by a medical practitioner (see Q16).

NOTE: To help prevent delays in processing your claim and prior to lodging this form, it is essential that you complete and attach a separate injury or disease details form for every injury or disease you have listed at Question 16. A medical practitioner should then complete the medical practitioner portion of the form and provide a diagnosis for the same injury or disease listed at Question 16. If you need more injury or disease details forms you can photocopy a blank form or download them from the DVA website www.dva.gov.au or phone DVA on 1800 VETERAN (1800 838 372).

☐ **Proof of Identity Documents** - on page 1 of the claim form – only if applicable, refer to the DVA Claim Information Sheet for details

☐ **A statement/contention** should be provided with your claim describing how you think your condition is related to your ADF employment

Supporting Documents - if you're still in the ADF and have access to your documentation, please provide as many of the following documents (relevant to your claim) as you can. This will help us assess your claim as quickly as possible:

☐ A copy of your service history (PMKeyS ADO Full Service Record)

☐ ADF medical documents from your ADF Medical Record including:

- Entry Medical board questionnaire
- Clinical notes
- Specialists reports
- Scans/MRI/x-ray reports
- Discharge medical information

☐ Your most recent SVA/ADF payslip

☐ Incident report - AC563 (if completed)

☐ Witness statement(s) if appropriate

☐ Authority to Participate in Civilian Sport (if appropriate)

☐ Hazardous Material Exposure Report (if appropriate)

If you've left the service or you don't have access to your documents, we can get this information directly from the ADF, including any discharge information on your behalf.

Don't forget to:

☐ Sign the authorisation and declaration on the claim form

Please ensure you have obtained a diagnosis prior to lodging the claim form.

If you need assistance contact the Department of Veterans' Affairs on **1800 VETERAN (1800 838 372)** or go to the DVA website **www.dva.gov.au**

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).

If you have a PMKeys number you should consider lodging your claim using DVA's online claim portal MyService. You can find MyService at https://www.dva.gov.au/myservice/#/

It is quick and easy to use.

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

When you lodge a claim with us you must prove your identity. You can establish your identity by providing original documents or certified copies from our approved list. Find out more at www.dva.gov.au/poi.

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 help prevent delays in processing your claim and prior to lodging this form, it is essential that you complete and attach a separate injury or disease details form for every injury or disease you have listed at Question 16. A medical practitioner should then complete the medical practitioner portion of the form and provide a diagnosis for the same injury or disease listed at Question 16. If you need more injury or disease details forms you can photocopy a blank form or download them from the DVA website: www.dva.gov.au or phone DVA on **1800 VETERAN (1800 838 372)**.

Privacy Notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

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

How to contact DVA

Please call **1800 VETERAN (1800 838 372)** during business hours.

You can also contact us by mail. Please address your correspondence to:

Department of Veterans' Affairs
GPO Box 9998
Brisbane QLD 4001

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 ☐ ▸ Representative type

☐ Ex-Service Organisation ☐ Legal ☐ Other

Full name

Organisation name *(if applicable)*

Is the representative trained under the Training and Information Program (TIP), or Advocacy Training and Development Program (ATDP)?

No ☐ Yes ☐ ▸ To what level?

Address

POSTCODE

Telephone

Home [ ] Work [ ]

Mobile Facsimile [ ]

Email address

The nominated representative must also sign this form on page 9

PART B — Personal details

2. DVA file number (if known)

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

4. Surname

5. Given name(s)

6. Previous name *(if applicable)*

7. Gender Male ☐ Female ☐ Gender X ☐

8. Date of birth (dd/mm/yyyy)

9. Residential address

POSTCODE

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

POSTCODE

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)

Full Time 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

Please complete and attach a separate **Injury or Disease Details Sheet (located at the back of this form)** for **every** injury or disease you are now claiming (Question **16**) or reassessment of previously accepted injuries or diseases (Question **17**), 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**.

☐ Claim for acceptance of liability for service related injuries or diseases that have not yet been accepted.

16. List all the injuries or diseases you are now claiming for.
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.

☐ Reassessment of previously accepted injuries or diseases.

17. List all previously accepted injuries or diseases which have become worse which you wish to have reassessed.
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.

18. 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

IMPORTANT - If liability is accepted you may be entitled to a supplement allowance paid fortnightly into an account at an Australian bank, credit union or building society.

19. Provide details of the Australian account you want your benefits to be paid into

Name of bank, credit union or building society

Branch

Address

POSTCODE

Account in the name of

Account number

BSB number

Account type (e.g. savings)

PART E Current General Practitioner or Medical Officer

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

21. Address

22. Telephone number

PART F About the benefits you are seeking

23. 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

24 If you are claiming for a mental health condition, are currently unable to work more than eight hours per week and require financial assistance, you may be eligible for veteran payment.

Veteran payment provides financial assistance while your liability claim for a mental health condition is determined. For further information refer to www.dva.gov.au/veteran-payment-overview

Would you like DVA to assess your eligibility for veteran payment?

No ☐ ▶ Please continue to **PART G**

Yes ☐ ▶ Please complete *Form D9333 Veteran Payment Details* and submit with this claim.

PART G Payments other than MRCA payments

DVA PAYMENTS

25. Do you currently receive compensation or a disability compensation payment from DVA?

No ☐

Yes ☐ ▶ Name of payment (e.g. disability compensation payment, MCRS payments)

COMMON LAW DAMAGES

26. 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

27. 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			
Commonwealth Superannuation Corporation (CSC) 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 Authorisations and declarations

I authorise DVA to obtain information and/or reports from medical practitioners, hospitals, clinics, insurance companies, Commonwealth Departments or Agencies, or other organisations in relation to this claim or its review.

The authority to obtain information relevant to your claim is contained in the provisions of the *Military Rehabilitation and Compensation Act 2004* (MRCA), *Veterans' Entitlements Act 1986* (VEA) and the *Safety, Rehabilitation and Compensation (Defence–related Claims) Act 1988* (DRCA). I authorise the department to consider my claim under one or more of the above Acts. I understand the information sought on the claim form is required to assess my eligibililty for compensation under all Acts (VEA, DRCA and MRCA) that may be applicable to the injury or disease which I am now claiming.

I agree that DVA may request from the Department of Defence information about my full service and medical history so that a comprehensive assessment of eligibility may be undertaken.

I agree that DVA may use personal information about me and disclose that information to other agencies and bodies, where DVA or those other agencies or bodies have a legitimate interest in such personal information *(refer to the list of such agencies or bodies below)*.

I authorise the Nominated Representative as in Question **1** noted on page 5 to represent me in respect of this claim and any review of a decision relating to this claim. This authorisation includes access to my personal information for purposes related to this claim and will continue until I:

- revoke this authorisation; or
- nominate another representative to represent me.

I declare that:

- the information I have given on this form and on any other attachments is true and accurate;
- I am aware that I must advise DVA:
  - immediately if I engage in any employment (whether paid, unpaid or voluntary) 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 or disease to which this claim for compensation relates; or
  - immediately if, during any period of certified incapacity for work, my injury or disease improves sufficiently to allow me to return to work; or
  - if I receive any monies by way of third party damages or other compensation mechanism for any injury or disease; or
  - 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 DVA;
- I am aware that a copy of this claim form may be sent to the Department of Defence where authorised by legislation;
- I am aware that there are penalties for making false statements.

Organisations we share information with

The information contained on the claim form may also be provided to another agency or body for their lawful purposes. These agencies or bodies include:

- the Repatriation Commission;
- the Military Rehabilitation and Compensation Commission;
- the Department of Defence (including a serving member's Service Chief);
- Centrelink;
- the Australian Taxation Office;
- the Child Support Agency;
- Medicare Australia;
- other State or Territory authorities to verify your eligibility for rebates or concessions relating to rates, electricity, transport, motor vehicles and ambulance;
- the legal representatives of the Department of Defence in relation to any common law (third party) damages action;

- Commonwealth Superannuation Corporation (CSC) (regarding any Commonwealth superannuation entitlements you may have);
- Commonwealth, State and Territory workers' compensation authorities in relation to a similar injury or disease;
- 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;
- your current and/or previous employer(s).

NOTE: The signature blocks on this page relate to the authorisation and declaration statements on page 10 of this form.

Claimant signature

CLAIMANT SIGNATURE

Date / /

By signing this form, in addition to the authorisations and declarations I make under Part H on the previous page, I declare that I am aware of the extent of information that will be collected by DVA to allow a comprehensive assessment of this claim.

The authorisation and declaration above must be signed by you or, if you cannot sign yourself due to physical or mental incapacity, your authorised representative will sign on your behalf.

NOTE: If the form is to be signed by your Legal Representative or approved person he/she must also complete **PART I** below.

Nominated representative signature

I am the representative nominated in Question **1** of this form. I assisted the claimant to complete this claim form ensuring that the contents accurately reflect the claimant's statements. I acknowledge that I have been nominated by the claimant to represent him/her in matters related to this claim and I will treat the information shared in a secure and confidential manner in order to maintain the claimant's privacy.

I consent to the use of my contact and personal information, provided at Question **1**, for communication and authentication purposes by DVA in relation to this claim.

NOMINATED REPRESENTATIVE SIGNATURE

Date / /

PART I Legal Representative's authority to act

Authority to act on behalf of the claimant.

Details of the person who is legally authorised to act on behalf of the claimant.

Please attach a certified copy of the instrument conferring authority to act on the claimant's behalf.

Full name

Address

POSTCODE

Telephone

Home | Work | Mobile

SIGNATURE OF LEGAL REPRESENTATIVE

Date / /

Australian Government
Department of Veterans' Affairs

Injury or disease details sheet

Surname	Given name(s)	DVA file number(s) (if known)

This section to be filled in by the claimant

Please fill out one sheet per injury or disease for which you are now claiming liability at Question 16. If this is a reassessment, do not complete this sheet.

Please detail the injury or disease you are now claiming and describe as fully as you can the signs and symptoms that make you notice the disability (e.g. pain in lower back, shortness of breath, loss of range of movement in right arm).

You are requested to ask your doctor to fill in the Medical Practitioner section on the next page before lodging your claim.

Injury or disease

Signs and symptoms

How do you believe your service caused, contributed to or aggravated this injury or disease?

If insufficient space, please attach a separate sheet

When did the injury happen (if applicable)? / /

Has a Defence injury report been completed? No ☐ Yes ☐ Please attach the Defence injury report. Do not know ☐

When did you first notice signs or symptoms of the injury or disease? / /

On what date did you first receive medical treatment for this injury or disease? / / (if known)

Name of your treating medical practitioner/hospital/specialist

For claimed conditions

Type of treatment or consultation provided (e.g. GP, specialist)

Has this injury or disease worsened or been aggravated since 1 July 2004? No ☐ Yes ☐

Is a medical practitioner's account attached in relation to completion of this injury or disease details sheet? No ☐ Yes ☐

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Read more: How DVA manages personal information

INJURY OR DISEASE DETAILS SHEET continued

Surname	Given name(s)	DVA file number(s) (if known)

This section to be filled in by a medical practitioner

Please supply a brief summary of the basis for each diagnosis and attach any reports you have that confirm the diagnosis. DVA will pay you for this service according to the relevant fee levels for the service.

NOTE: The claim for this condition must be lodged before payment of medical account can be made.

Medical diagnosis

Basis for diagnosis

Is this diagnosis Confirmed ☐ Provisional ☐

When did the claimant first consult you for this injury or disease? / /

Please advise approximate date of onset of the injury or disease based on available notes / /

Address

POSTCODE

Telephone [ ]

Medical practitioner stamp
(Please include Provider Number)

MEDICAL PRACTITIONER'S SIGNATURE

Date / /

Australian Government
Department of Veterans' Affairs

Injury or disease details sheet

Surname	Given name(s)	DVA file number(s) (if known)

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Injury or disease

Signs and symptoms

How do you believe your service caused, contributed to or aggravated this injury or disease?

If insufficient space, please attach a separate sheet

When did the injury happen (if applicable)? / /

Has a Defence injury report been completed? No ☐ Yes ☐ Please attach the Defence injury report. Do not know ☐

When did you first notice signs or symptoms of the injury or disease? / /

On what date did you first receive medical treatment for this injury or disease? / / (if known)

Name of your treating medical practitioner/hospital/specialist

For claimed conditions

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Please advise approximate date of onset of the injury or disease based on available notes / /

Address

POSTCODE

Telephone [ ]

Medical practitioner stamp
(Please include Provider Number)

MEDICAL PRACTITIONER'S SIGNATURE

Date / /

Australian Government
Department of Veterans' Affairs

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If insufficient space, please attach a separate sheet

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For claimed conditions

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Is a medical practitioner's account attached in relation to completion of this injury or disease details sheet? No ☐ Yes ☐

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Basis for diagnosis

Is this diagnosis Confirmed ☐ Provisional ☐

When did the claimant first consult you for this injury or disease? / /

Please advise approximate date of onset of the injury or disease based on available notes / /

Address

POSTCODE

Telephone [ ]

Medical practitioner stamp
(Please include Provider Number)

MEDICAL PRACTITIONER'S SIGNATURE

Date / /

Save Print Clear