IMPORTANT

Australian Government
Department of Veterans' Affairs

Application for Loss of Earnings Allowance

Under the *Veterans' Entitlements Act 1986* (VEA)

Loss of earnings allowance

Loss of earnings allowance is a form of compensation paid under the *Veterans' Entitlements Act 1986 (VEA)* for the loss of salary, wages or earnings due to an absence from work in certain circumstances. For veterans, these circumstances are obtaining treatment for a VEA accepted disability, or attending an appointment arranged by the Department of Veterans' Affairs (DVA). For persons other than veterans it can include having to take time off work to travel as an authorised attendant for a veteran.

The amount paid is:

- equivalent to the special (TPI) rate of disability compensation payment (less any disability compensation payment currently received); or
- the amount of earnings lost whichever is the lesser.

An application for loss of earnings must be lodged within **12 months** of the beginning of the period of loss of earnings being claimed.

In certain circumstances loss of earnings allowance may be paid in advance to an eligible veteran.

NOTE: Where liability has been accepted for a service injury or disease under the *Safety, Rehabilitation and Compensation (Defence–related Claims) Act 1988* (DRCA) or the *Military Rehabilitation and Compensation Act 2004* (MRCA) and you wish to claim incapacity payments as a result of an inability (or reduced ability) to work because of this service injury or disease, you should complete the form D1360 - *Claim for Incapacity for Service/Work.*

Assistance from ex-service organisations

You are encouraged to seek the assistance of an ex-service organisation of your choice in lodging this application.

Contact telephone numbers for these organisations can be found in local telephone directories or by contacting DVA in your State.

Assistance from DVA

DVA staff can also help to complete this form.

Proving your identity to DVA

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.

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

Giving false or misleading information is a serious offence.

If any details you give on this form change, you must tell the Department within 21 days.

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's details

To be completed only if you wish to nominate a representative to act for you in matters relating to this application

1 Do you wish to nominate a representative or organisation to act for you in matters relating to this application?

No ☐ ▶ Go to **Question 3**

Yes ☐ ▶ Full name of nominated representative

Organisation *(if applicable)*

Address

POSTCODE

Telephone

Home [ ]

Work [ ]

Mobile

Facsimile [ ]

E-mail address

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

No ☐

Yes ☐ ▶ To what level?

PART B Applicant's details

To be completed by the person who lost salary, wages or earnings, including a self-employed person

3 DVA file number *(if known)*

4 Your surname

5 Your given names

6 Postal address

POSTCODE

7 Telephone number(s)

Home [ ]

Work [ ]

Mobile

Facsimile [ ]

E-mail address

Grounds for applying for loss of earnings allowance

8 **Please tick ONE box to indicate the grounds for your application for loss of earnings.**

Please read all five options to ensure you are selecting the correct option for your circumstances.

FOR VETERANS ONLY

☐ **(8a)** I have received treatment for an accepted disability (including waiting for the supply or repair of an artificial limb or other surgical aid), and have lost salary, wages or earnings as a result.

Accepted disability	Period when treated?
	/ / to / /
	/ / to / /

☐ **(8b)** I have attended an appointment arranged by the Department for the investigation of a claim for disability compensation payment or compensation increase.

Appointment with	Length of appointment

☐ **(8c)** I have used all or part of my employer–provided sick leave to cover absences due to my accepted disability (including waiting for the supply or repair of an artificial limb or other surgical aid) or to attend appointments arranged by the Department. I now do not have enough sick leave to cover a new absence caused by a disability that is not war caused.

First, please indicate the dates you were absent from work and paid sick leave due to your accepted disability.

Accepted disability	Period when treated?
	/ / to / /
	/ / to / /

Now, please indicate the dates you were later absent from work because of a non–war caused disability without sick leave to cover this absence.

Name of treating Doctor	Period absent from work without sick leave?
	/ / to / /
	/ / to / /

FOR OTHERS ONLY

☐ **(8d)** I am an authorised attendant who accompanied a veteran travelling for treatment purposes or to an appointment arranged by the Department. ***(Please also complete Question 13).***

Date of appointment	Purpose of appointment
/ /	

☐ **(8e)** I am a legal personal representative for a veteran or dependent of a veteran that has claimed a disability compensation payment. ***(Please also complete Question 13).***

Reason for absence

Period for which loss of earnings is claimed

9 **Period for which the allowance is claimed.**

From / / To / /

From / / To / /

Self-employed declaration

Only complete this section if you were self–employed during the period claimed, otherwise go to **Question 12**

10 **Please describe how you incurred a loss of earnings as a result of being absent from your business (e.g. paying wages to a temporary employee).**

11 **Your total earnings or salary lost during this period.**

$

Please provide your last three Business Activity Statements with this form.

Declaration

I declare that I am a self-employed person conducting business as:
occupation

at
address of business

POSTCODE

and my normal working hours are:

Start and finish times (e.g. 8 am to 5 pm)

am/pm to am/pm

Days of the week (include weekends, e.g. Monday to Friday)

I understand that it is an indictable offence to make a false or misleading statement in connection with, or in support of, an application for allowance, or to obtain a payment of a benefit by means of a false or misleading statement, or impersonation, or fraudulent device. I declare the information I have provided on this statement is true and correct in every respect.

YOUR SIGNATURE

Date / /

Other details (for ALL applicants)

12 **Have you received or are you entitled to receive, or are you claiming:**
- **any benefits from Centrelink;**
- **any benefits from Comcare or MCRS under the DRCA or MRCA;**
- **any payments from a third party, such as income protection payments;**

in respect of these loss of earnings?

No ☐

Yes ☐ Amount received $ Period / / to / /

Type of payment

Insurance company name

Centrelink reference (if applicable)

13 **If you ticked either 'travel attendant' or 'legal personal representative' at Question 8, please provide the following details.**

Veteran's or dependant's full name

Veteran's or dependant's DVA File No.

Veteran's or dependant's address

POSTCODE

Declaration and consent

NO REPRESENTATIVE APPOINTED

Please complete if you do not have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

REPRESENTATIVE APPOINTED

Please complete if you have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I authorise the nominated representative or organisation to act for me in respect of this application and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:

- revoke the authorisation; or
- nominate another representaive or organisation to act for me.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

PHYSICAL OR MENTAL INCAPACITY

If the veteran is unable to sign due to physical or mental incapacity, please sign on behalf of the veteran at either 'NO REPRESENTATIVE APPOINTED' or 'REPRESENTATIVE APPOINTED' above and provide the following details.

Please attach a copy of the document that gives you legal authority to act on behalf of the veteran, unless this has already been provided to the Department.

Your full name

Address

POSTCODE

Telephone

Home [ ]

Work [ ]

I declare that I am authorised to act on behalf of the veteran in matters relating to this application. *(Tick one box below).*

☐ I have attached a copy of the authority document or a medical certificate attesting to this incapacity.

☐ I have provided DVA with a copy of *Type of document*

YOUR SIGNATURE

Date / /

PART C Unpaid absence from work report

If you are an employee, your employer needs to complete this part to confirm your absence from work and wages lost.

14 Name of employee/applicant

15 Occupation

16 Please describe the applicant's normal working hours (including regular overtime).

Start & finish times *(e.g. 8am to 5pm)*	Days of the week (incl. weekends) *(e.g. Monday to Friday)*

17 Record details of lost salary, wages or earnings for the period(s) indicated by the applicant in PART B Question 9.

- If the applicant would normally work overtime or receive other penalty rates please show this amount.
- If the rate of remuneration has varied show the appropriate rate against the relevant period.

Period of **unpaid** absence	No. of hours	Basic hourly wage rate	Penalty rate	Overtime rate	TOTAL wages lost
/ / to / /		$	$	$	$
/ / to / /		$	$	$	$
/ / to / /		$	$	$	$

Sick leave credits

Only complete Questions **18**, **19**, **20** and **21** if the applicant has completed PART B Question **8c** "used all or part of employer–provided sick leave".

18 Do you confirm the period indicated in PART B Question 8?

No ☐ ▶ Please give reason

Yes ☐

Please attach copies of any relevant medical certificates

19 Amount of sick leave credit (if any) available to the applicant at the start of and/or during the period in Question 17 above.

hours

20 What is the maximum sick leave credit at full pay per year?

days

21 What is the anniversary date for sick leave credit purposes?

/ /

Compensation details

22 Has the applicant received or is the applicant entitled to receive payment by way of compensation, gratuity, or payment under a contract, arrangement or agreement (including a contract of insurance) in respect of the loss of earnings during the specified period on this form?

No ☐

Yes ☐ ▶ Amount received

$

Type of payment (e.g. worker's compensation)

Insurance company

Employer's details

23 Your name (please PRINT)**.**

24 Your position title

25 Your contact phone number [ ]

26 Business name

27 Business address

POSTCODE

28 Signature

YOUR SIGNATURE

Date

/ /

PART D Treating doctor report

To be completed by a treating doctor in respect of the veteran's absence from work for treatment purposes.

The Department will pay for this service according to the *Schedule of Fees*. An account, showing the time spent in consultation, must be lodged before payment can be made.

29 Veteran's full name

30 How long has the veteran been a patient of your practice?

The veteran has claimed an absence from work as a result of having received **treatment** for their accepted condition(s) specified in PART B at **Question 8**.

31 Please list the medical diagnosis for the condition(s) treated.

NOTE: it must be the **treatment** that prevents the veteran from working and not incapacity for the condition itself. **Treatment** can include waiting for the supply or repairs to an artificial aid or appliance.

32 Did you provide <u>treatment</u> for the above condition(s)?

No ☐ ▶ Please go to **Question 33**

Yes ☐ ▶ Please provide details

	Condition 1	Condition 2
Details of **treatment** provided		
Dates of consultations, including hospitalisations		
Period(s) off work authorised by yourself	/ / to / /	/ / to / /
	/ / to / /	/ / to / /
How is treatment preventing the veteran from working?		

If insufficient space, please attach a separate sheet

33 Did you arrange <u>treatment</u> for the listed condition(s) with specialists or other health workers?

No ☐
Yes ☐ ▶ Please provide details

	Condition 1	Condition 2
Provider's name		
Address	POSTCODE	POSTCODE
Details of **treatment** provided		
Dates of consultations, including hospitalisations		
Period(s) off work authorised by provider	/ / to / /	/ / to / /
	/ / to / /	/ / to / /
	/ / to / /	/ / to / /
	/ / to / /	/ / to / /
How is treatment preventing the veteran from working?		

If insufficient space, please attach a separate sheet

34 **Are you aware of any other <u>treatment</u> provided** (i.e physio)**?**

No ☐
Yes ☐ ▶ Please provide details of the specialists or other health worker(s) who provided the treatment if not provided or arranged by yourself.

Name	Address	Profession
	POSTCODE	
	POSTCODE	
	POSTCODE	

35 **Your name**

36 **Address**

POSTCODE

37 **Telephone number**

[ ]

38 **Signature**

YOUR SIGNATURE

Date

/ /

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