



LONG SERVICE LEAVE AUTHORITY TOTAL INCAPACITY CLAIM FORM



Which Scheme/Industry? (Please (✓) tick one box) Construction Cleaning Community Security

Photo I.D Required
(Copy of Driver's Licence,
Proof of Age Card or Passport)

Personal Details

Registration No: _____

Date of Birth: ____/____/____

Employee Surname _____

Given Names _____

This is the address
your payment
will be posted to

Street _____

Email Address _____

Suburb _____

State _____

Post Code _____

Type of work performed _____

Mobile Phone No (Contact Phone No). _____

Interstate Service

If you are registered and have service recorded in an interstate portable long service leave scheme you may add this service to your ACT payment.

State _____

Registration No. (if known) _____

State _____

Registration No. (if known) _____

Workers' Compensation

Have you been on workers' compensation for over 6 months since 1 October 1981?

Yes / No (Circle)

If yes, for what period? ____/____/____ to ____/____/____

Tax File Number

Your Tax File Number _____

The Authority is required to deduct tax from your payment. You have no legal obligation to quote a tax file number. However, if you do not provide a tax file number tax will be deducted from your payment at the highest rate. A PAYG Payment Summary will be provided by the Authority.

Details about your Last employer

Who was your last employer in the **relevant** industry in the ACT?

Employers Name _____

Date you finished: ____/____/____

* Were you made redundant from your last employer? Yes No

* Have you been paid any long service leave directly by your past employer? Yes No

✓ I acknowledge that I have read the privacy information on the back of this claim form.

Employee Signature

Signature to claim **(Photo I.D. attached/enclosed)** (Tick Yes)

Date: ____/____/____

Certification by Medical Practitioner

Note: To be eligible to claim on the basis of total incapacity the applicant must have an illness or injury that permanently prevents him/her from continuing work in the relevant industry.

(To be completed by a
Medical Practitioner)

Applicant's Surname _____

Given Names _____

State the nature of illness or injury _____

(a) Can the patient do his or her usual type of work?

Yes

No

(b) Will the patient be able to return to work in the relevant industry?

Yes

No

I examined the above patient on ____/____/____ and in my opinion this person has been unable to work in the relevant industry since ____/____/____.

Medical Practitioners Signature _____

Date: ____/____/____

Name (Please print): _____

Qualifications: _____

Surgery Address: _____

Phone No: _____

Street Address:

Trevor Pearcey House
Unit 1, 28 Thynne Street, BRUCE ACT 2617

Postal Address:

Reply Paid 234
CIVIC SQUARE ACT 2608
Email: enquiry@actleave.act.gov.au

Office Hours

8.30am to 4.30pm
Freecall 1800 655 060
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