

Queensland



WorkCover Queensland Act 1996

WORKCOVER QUEENSLAND REGULATION 1997

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(includes amendments up to SL No. 197 of 2001)**

Reprint No. 2C

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Information about this reprint

This regulation is reprinted as at 9 November 2001. The reprint shows the law as amended by all amendments that commenced on or before that day (Reprints Act 1992 s 5(c)).

The reprint includes a reference to the law by which each amendment was made—see list of legislation and list of annotations in endnotes.

Minor editorial changes allowed under the provisions of the Reprints Act 1992 have been made to use aspects of format and printing style consistent with current drafting practice (s 35).

This page is specific to this reprint. See previous reprints for information about earlier changes made under the Reprints Act 1992. A table of earlier reprints is included in the endnotes.

Also see endnotes for information about—

- **when provisions commenced**
- **editorial changes made in earlier reprints.**

Queensland



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WORKCOVER QUEENSLAND REGULATION 1997

[as amended by all amendments that commenced on or before 9 November 2001]

PART 1—PRELIMINARY

1 Short title

This regulation may be cited as the *WorkCover Queensland Regulation 1997*.

2 Commencement

This regulation commences on 1 February 1997.

3 Definitions

In this regulation—

“**actuarial standard**” means ‘Professional Standard 300—Actuarial reports and advice on outstanding claims in general insurance’ issued by the Institute of Actuaries of Australia (ACN 000 423 656).¹

“**actuary**” means an actuary approved by WorkCover.

“**AMA guide**” means the ‘Guides to the Evaluation of Permanent Impairment’ published by the American Medical Association.

“**arbiter**” means the actuarial arbiter appointed under section 129.

“**assessed premium**”, for an employer, means premium calculated using the employer’s wages for a period of insurance.

“**binaural tables**” means the binaural tables recommended and published for the time being by NAL.

¹ A copy of the standard may be inspected at the WorkCover’s head office at 280 Queen Street, Brisbane.

“**central estimate**” has the meaning given by the actuarial standard, section 10.

“**claim**”, for part 9, means—

- (a) an application for compensation; or
- (b) a claim for damages.

“**excess period**” see section 69 of the Act.

“**financial quarter**” means a period of 3 months beginning on 1 January, 1 April, 1 July or 1 October.

“**further premium**” for an employer means an amount, other than assessed premium or provisional premium, payable by an employer to WorkCover under the Act, and includes the following—

- (a) arrears of premium;
- (b) additional premium under section 8(4);
- (c) interest on premium under section 10(2);
- (d) an amount of unpaid premium or a payment or penalty payable under section 61(2)² of the Act;
- (e) additional premium for late payment under section 65 or 66³ of the Act;
- (f) additional premium under section 67⁴ of the Act;
- (g) an amount payable under section 71⁵ of the Act.

“**hearing loss tables**” means the hearing loss tables recommended and published for the time being by NAL.

“**lower extremity**” see AMA guide.⁶

“**modified barthel index**” means the guidelines and modified scoring of the barthel index stated in the article ‘Improving the Sensitivity of the Barthel Index for Stroke Rehabilitation’ by S Shah, F Vanclay and

2 Section 61 (Recovery of compensation and unpaid premium) of the Act

3 Section 65 (Additional premium payable if premium not paid) or 66 (Further additional premium payable after appeal to industrial magistrate) of the Act

4 Section 67 (Additional premium for out-of-State workers) of the Act

5 Section 71 (Employer may insure against payment for excess period) of the Act

6 Under the AMA guide, the lower extremity has 6 sections, namely, the foot, the hindfoot, the ankle, the leg, the knee and the hip.

B Cooper published in the Journal of Clinical Epidemiology, 1989, vol 42 no 8, pp 703-709.

“**NAL**” means the National Acoustic Laboratories (Cwlth).

“**ophthalmologists guide**” means the publication ‘A Guide to Members of the Australian College of Ophthalmologists’ published for the time being by the Australian College of Ophthalmologists.

“**premium**” includes assessed premium, provisional premium and further premium.

“**presbycusis correction table**” means the presbycusis correction table recommended and published for the time being by NAL.

“**provisional premium**”, for an employer, means premium calculated using a reasonable estimate of wages for a period of insurance.

“**prudential margin**” has the meaning given by the actuarial standard, section 12.

“**risk free rate of return**” has the meaning given by the actuarial standard, section 13.

“**upper extremity**” see AMA guide.⁷

4 Scheme solvency—Act, s 5

(1) For section 5(5)(b) of the Act, WorkCover’s assets must exceed WorkCover’s liabilities by at least 5% of WorkCover’s outstanding claims provisions at the end of its last financial year.

(2) To remove any doubt, the amount required under subsection (1) is in addition to the minimum solvency or capital adequacy standards required under section 5(5)(a) of the Act.

⁷ Under the AMA guide, the upper extremity has 4 parts, namely, the hand, the wrist, the elbow and the shoulder.

PART 2—EMPLOYER INSURANCE

Division 1—Policies and premium assessments

5 Application for policy

An application for a policy must be made to WorkCover in the approved form.

6 Policies and renewals

(1) On payment of the premium shown as payable in a premium notice issued by WorkCover to an employer, WorkCover must issue to the employer a policy, in the approved form, for the period of insurance stated in the notice.

(2) A policy has no force or effect until—

- (a) WorkCover receives the premium payable to WorkCover for the policy or its renewal; or
- (b) WorkCover enters into an instalment plan for the policy under section 10.⁸

7 Assessment of premium

(1) This section does not apply to a policy for household workers.

(2) WorkCover must assess premium payable under a policy for each period of insurance shown in a premium notice.

(3) The following formula must be used to calculate premium—

$$\mathbf{P = AP - PPP + PP + FP}$$

(4) However, if the policy relates to government workers covered under an arrangement approved by WorkCover, WorkCover may assess premium at the rate decided by WorkCover after taking actuarial advice.

⁸ Section 10 (Payment of premium by instalments)

(5) For a period of insurance before 1 July 1997, an assessment of premium must be made in accordance with the provisions of the Act in force at the time of the relevant period of insurance.

(6) If, after the premium is assessed, WorkCover is satisfied that premium for the period has been overpaid, WorkCover must refund or credit the amount of overpayment to the employer to whom the premium notice is given.

(7) If, after the premium is assessed, WorkCover is satisfied that premium for the period has been underpaid, the employer to whom the premium notice is given must pay the premium as assessed.

(7A) The premium for a policy assessed under this section may be increased to take account of the following—

- (a) GST payable for the supply of the policy;
- (b) stamp duty payable under the *Stamp Act 1894* in respect of the policy.

(8) In subsection (3)—

“P” means the premium payable.

“AP” means assessed premium for the preceding period of insurance.

“PPP” means provisional premium for the preceding period of insurance.

“PP” means provisional premium for the period of insurance.

“FP” means further premium.

8 Declaration of wages

(1) This section does not apply to an employer who employs only household workers.

(2) Each employer, other than a self-insurer, must, on or before 31 August in each year, lodge with WorkCover a declaration of wages so WorkCover can assess the employer’s premium.

(3) The declaration must be in—

- (a) the approved form; or
- (b) with WorkCover’s approval—another form acceptable to WorkCover.

(4) If an employer does not comply with subsection (2), the employer must pay an additional premium under schedule 1.

(5) The additional premium payable under schedule 1 is the amount specified opposite the time after 31 August in a year when the employer complies with subsection (2).

9 Value of board and lodging

(1) This section applies if an employer provides, or is to provide, board to a worker during a period of insurance.

(2) The value of board provided is taken to be wages paid, or to be paid, by the employer to the worker.

(3) For each week the employer provides, or is to provide board, the value of board is not less than—

- (a) the weekly allowance for board provided for under the industrial instrument governing the calling in which the worker is engaged; or
- (b) if paragraph (a) does not apply—6% of QOTE.

(4) In this section—

“**board**” means accommodation, meals, laundry services or any other entitlement having a monetary value provided when lodging.

10 Payment of premium by instalments

(1) WorkCover may accept payment of premium by instalments under an instalment plan approved by WorkCover if WorkCover is satisfied that payment of premium by the due date would impose financial hardship on the employer.

(2) The instalment plan is subject to the following conditions—

- (a) interest at a rate specified by the board by industrial gazette notice must be added to the amount of each instalment;
- (b) interest must be calculated from the due date;
- (c) the interest rate that applies at the start of the instalment plan remains constant until the plan ends;

- (d) on acceptance of the instalment plan, the employer must, if required by WorkCover, enter into a payment arrangement acceptable to WorkCover;
- (e) if an instalment of premium is not paid on or before the due date for payment of the instalment—
 - (i) the total amount of unpaid instalments and interest on outstanding instalments to that day immediately becomes payable to WorkCover; and
 - (ii) additional premium under section 11 applies to the unpaid instalments and interest; and
 - (iii) the policy for which the premium is payable ceases to have effect; and
 - (iv) the employer contravenes section 52⁹ of the Act.

11 Additional premium for late payment—Act, ss 65 and 66

(1) This section applies if, on or before the due date, an employer does not pay—

- (a) the amount of premium payable under a premium notice; or
- (b) the amount by which a final assessment of premium by an industrial magistrate or the Industrial Court is more than the amount of assessment of premium paid under section 490(4) of the Act.

(2) To remove any doubt, this section does not apply if WorkCover has accepted payment of the amount under an instalment plan and instalments are paid under the plan.

(3) This section does not apply to an employer who employs only household workers.

(4) The additional premium payable under section 65 or 66 of the Act is—

- (a) if payment of the amount is made to WorkCover within 30 days after the due date—5% of the amount; or
- (b) if payment of the amount is made to WorkCover after 30 days but within 60 days of the due date—10% of the amount; or

9 Section 52 (Employer's obligation to insure) of the Act

- (c) if payment of the amount is made to WorkCover after 60 days of the due date or if no payment is made—10% of the amount plus interest at the annual rate mentioned in section 10(2)(a) for the period from the due date, or a later date decided by WorkCover, until the amount and all additional premium is paid to WorkCover.

12 Deemed premium—s 31

(1) For section 31,¹⁰ deemed premium for a self-insurer, for a financial year of the self-insurer’s licence, is the notional premium calculated under the formula—

$$D = \frac{W \times R}{100}$$

(2) In subsection (1)—

“D” means deemed premium.

“W” means—

- (a) the wages of the self-insurer for the financial year of licence; or
- (b) if the self-insurer has only been self-insured for part of a financial year—a reasonable estimate of the wages of the self-insurer for the financial year of licence.

“R” means the rate for the self-insurer’s industry or business specified in the notice under section 58¹¹ of the Act that applies to the financial year of licence.

13 Deemed premium—Act, s 515(2)(a)

(1) For section 515(2)(a)¹² of the Act, deemed premium, for an employer for a period of insurance or for a self-insurer for a financial year of the self-insurer’s licence, is the notional premium calculated under the formula—

$$D = \frac{W \times R}{100}$$

10 Section 31 (Annual levy—Act, s 111)

11 Section 58 (Setting of premium) of the Act

12 Section 515 (Starting appeals) of the Act

(2) In subsection (1)—

“**D**” means deemed premium.

“**W**” means—

- (a) the wages of the employer for the preceding period of insurance or of the self-insurer for the preceding financial year of licence; or
- (b) if the employer or the self-insurer has only been insured or self-insured for part of a period of insurance or part of a financial year—a reasonable estimate of the wages of the employer for the period of insurance or of the wages of the self-insurer for the financial year of licence.

“**R**” means the rate for the employer’s or self-insurer’s industry or business specified in the notice under section 58¹³ of the Act that applies to the period of insurance or financial year of licence.

14 Cancellation of policy on ceasing to employ workers

(1) This section applies if an employer wishes to cancel a policy because the employer has ceased to employ workers.

(2) This section does not apply to an employer who employs only household workers.

(3) The employer must give WorkCover—

- (a) written notice that the employer—
 - (i) has ceased to employ workers on and from a date specified in the notice; and
 - (ii) wishes to cancel the policy; and
- (b) written details of the employer’s wages in relation to the period starting on 1 July last preceding the day on which employment of workers ceased and ending on that day.

(4) WorkCover must assess the premium payable by the employer for the period during which the employer was required by the Act to maintain a policy.

13 Section 58 (Setting of premium) of the Act

(5) If the premium paid by the employer for the period mentioned in subsection (3) is—

- (a) greater than the amount of premium assessed under subsection (3)—WorkCover must refund to the employer the amount overpaid; or
- (b) less than the amount of premium assessed under subsection (3)—the employer must pay WorkCover the amount of the deficit on or before the due date under a final premium notice issued for the amount of the deficit.

15 Documents to be kept—Act, s 469

(1) An employer or contractor must keep the following documents for section 469 of the Act—

- (a) the time and wages book, or wages book, and the register of employees, required to be kept under the Industrial Relations Act;
- (b) documents, or accurate and complete copies of documents, required to be kept under a law of the Commonwealth for payments made to the employer's workers or contractors for the performance of work, including, for example—
 - (i) group certificates; and
 - (ii) group employer's reconciliation statements; and
 - (iii) prescribed payment system payer's reconciliation statements;
- (c) the person's profit and loss account, to the extent it relates to amounts paid for wages for workers, or to contractors.

(2) However, a document mentioned in subsection (1)(b) or (c) need not contain information an employer or contractor reasonably believes is confidential and not necessary to enable WorkCover to calculate the person's actual expenditure on wages or for contracts for the period to which the document relates.

Examples—

1. Income and profit lines.
2. Tax file numbers.

(3) An employer or contractor need not comply with subsection (1) if—

- (a) WorkCover has given the employer or contractor notice that a document need not be kept, and the notice remains in force; or
- (b) the employer or contractor was a corporation and has been wound-up.

(4) In this section—

“**worker**” does not include a household worker.

Division 2—Employer excess

16 Excess period—Act, s 69

(1) The excess period is calculated having regard to—

- (a) the days worked under a worker’s contract of service with an employer when the injury was sustained; and
- (b) the period—
 - (i) if the worker’s total incapacity is ongoing—of 1 week from when the worker’s entitlement to weekly payment of compensation starts; or
 - (ii) if the worker’s total incapacity is interrupted—of the worker’s continuing incapacity because of the injury.

(2) If a worker is required to work for a stated number of days only, the excess period is up to the stated number of days, or 4 days, whichever is the lesser.

Example of excess period for subsection (1)(b)(i)—

1. A worker is employed 5 days a week (Monday to Friday). The worker sustains an injury on Tuesday and immediately stops work to attend for medical treatment. The treating doctor certifies total incapacity for work for 2 weeks. The excess period is 4 days (from Wednesday to Monday).

Example of excess period for subsection (1)(b)(ii)—

1. A worker is employed 5 days a week (Monday to Friday). The worker sustains an injury on Wednesday, attends for medical treatment that day and the treating doctor certifies total incapacity for 2 days. The initial excess period is 2 days (Thursday and Friday).

The worker returns to work on Monday and works Monday, Tuesday and Wednesday. However, the incapacity from the same

injury continues and the worker obtains a subsequent medical certificate for 2 days. The balance of the excess period is 2 days (Thursday and Friday). The total excess period is 4 days.

Examples of excess period for subsection (2)—

1. A worker is employed 2 days a week (Thursday and Saturday). The worker sustains an injury on Saturday and continues to work until the end of the day. The worker attends for medical treatment the following Monday and the treating doctor certifies total incapacity for work for 10 days. The excess period is 2 days (Thursday and Saturday).
2. A worker is employed for 1 day only. The worker sustains an injury, attends for medical treatment and the treating doctor certifies total incapacity for 3 days. The excess period is 1 day.

17 Employer's election to insure against payment for excess period—Act, s 71

(1) An employer may only elect to insure against the employer's liability to pay for the excess period for a period of insurance—

- (a) at the start of a new policy—by making written application to WorkCover on the application for a policy; or
- (b) on renewal of a policy—by making written application to WorkCover on or before 31 August in the renewed period of insurance.

(2) The employer's election to insure for a period of insurance—

- (a) applies from the day the employer's written application is received by WorkCover, or the start of the policy, whichever is the later; and
- (b) applies until the end of the period of insurance; and
- (c) cannot be withdrawn by the employer.

(3) However, if the employer elected to insure for the preceding period of insurance and elects to insure for the current period of insurance on or before 31 August in the current period of insurance, the election applies from the start of the current period of insurance.

(4) If the employer does not pay the premium for the period by the due date for payment of the premium or an instalment of premium under an instalment plan, the employer is taken never to have made the election to insure.

18 Amount payable to insure against payment for excess period—Act, s 71

(1) This section applies if an employer elects to insure under section 71 of the Act against the employer's liability to pay for the excess period.

(2) The amount payable by the employer is the greater of—

- (a) 8.5% of the employer's premium for the period of insurance; or
- (b) \$10.00.

(3) For subsection (2)(a), the employer's premium is—

- (a) if the employer elects to insure for the period of insurance and did not elect to insure for the preceding period of insurance—

$$P = PP; \text{ or}$$

- (b) if the employer elects to insure for the period of insurance and elected to insure for the preceding period of insurance—

$$P = AP - PPP + PP; \text{ or}$$

- (c) if the employer did not elect to insure for a period of insurance and elected to insure for the preceding period of insurance—

$$P = AP - PPP$$

(4) In this section—

“P” means premium.

“AP” means assessed premium for the preceding period of insurance.

“PPP” means provisional premium for the preceding period of insurance.

“PP” means provisional premium for the period of insurance.

Division 4—Self-insurance**30 Application fees—Act, s 100**

For section 100 of the Act, the amount of the application fee is—

- (a) for a single employer—\$15 000; or
- (b) for a group employer—\$20 000.

31 Annual levy—Act, s 111

(1) For section 111 of the Act, the amount of the levy payable by a self-insurer for each financial year or part of a financial year of a licence is an amount calculated under the formula—

$$L = (D - EDP + ED) \times R.$$

(2) In subsection (1)—

“**L**” means annual levy.

“**D**” means deemed premium for the self-insurer for the preceding financial year of licence calculated under section 12 using the wages of the self-insurer for the year of licence.

“**EDP**” means deemed premium for the self-insurer for the preceding financial year of licence calculated under section 12 using estimated wages of the self-insurer for the year of licence.

“**ED**” means deemed premium for the self-insurer for the current financial year of licence calculated under section 12 using estimated wages of the self-insurer for the year of licence.

“**R**” means the rate published in the industrial gazette notice under section 111¹⁴ of the Act.

32 Conditions of licence—Act, s 112

A self-insurer’s licence is subject to the following conditions—

- (a) for each year, or part of a year, of a licence—the self-insurer must lodge with WorkCover a declaration in the approved form of the self-insurer’s wages so that WorkCover can calculate the levy payable under section 31;
- (b) the unconditional bank guarantee lodged under section 113 of the Act—
 - (i) must be issued by a bank or Queensland Treasury Corporation; and
 - (ii) must not be issued by a bank that is a related body corporate to the self-insurer; and

14 Section 111 (Annual levy payable) of the Act

- (iii) must be satisfactory to WorkCover;
- (c) the annual assessment of estimated claims liability under section 113(3) of the Act must be carried out under guidelines issued by WorkCover by industrial gazette notice.

33 Premium payable after cancellation of self-insurer's licence—Act, s 125

(1) This section applies if a former self-insurer continues to be an employer after the self-insurer's licence is cancelled.

(2) The premium payable by the former self-insurer for the first 2 periods of insurance after cancellation is to be calculated according to the method and at the rate specified by WorkCover by industrial gazette notice under section 58¹⁵ of the Act as if the employer were a new employer.

(3) However, the rate under subsection (2) cannot be less than the rate calculated under the following formula—

$$R = \frac{(P + L + A) \times 100}{W}$$

(4) In subsection (3)—

“**R**” means the premium rate.

“**P**” means the actual payments made by the former self-insurer, less recoveries received and payments made that are the equivalent of amounts payable for the excess period, for claims incurred during the final period of licence.

“**L**” means an actuarial estimate of the outstanding liability at the end of the self-insurer's licence for claims incurred during the final period of licence, excluding liability for the excess period.

“**A**” means the administrative costs associated with claims incurred during the final period of licence, calculated by multiplying P + L by 0.095.

“**W**” means the wages of the self-insurer during the final period of licence.

“**final period of licence**” means—

- (a) for an employer licensed as a self-insurer for 3 or more years immediately before cancellation of the licence—3 years; or

¹⁵ Section 58 (Setting of premium) of the Act

- (b) for an employer licensed as a self-insurer for less than 3 years immediately before cancellation of the licence—the period of the licence.

34 Actuarial procedure—self-insurers

(1) Actuarial estimates required under this division must be carried out by an actuary approved by WorkCover.

(2) The actuary must calculate the estimate under guidelines issued by WorkCover by industrial gazette notice.

PART 3—OTHER INSURANCES

Division 1—Students

35 Insurance of work experience students

(1) In this section—

“**corporation**” means the corporation sole of the Minister established under the *Education (General Provisions) Act 1989*.

“**educational establishment**” has the meaning given in the *Education (Work Experience) Act 1996*, section 5.

“**student**” has the meaning given in the *Education (Work Experience) Act 1996*, section 3.

“**work experience**” has the meaning given in the *Education (Work Experience) Act 1996*, section 4.

“**work experience place**” means a place where work experience is, or is to be, provided for a student.

(2) WorkCover may enter into a contract of insurance with an educational establishment or the corporation to insure the educational establishment or the corporation against liability for compensation for injury to a student arising out of work experience.

(3) For this section, when deciding whether an injury arises out of, or in the course of, work experience, chapter 1, part 4, division 6, subdivisions 2 and 3¹⁶ of the Act apply as if

- (a) the student were a worker; and
- (b) work experience were the employment; and
- (c) the work experience place were the place of employment; and
- (d) the corporation or the educational establishment were the employer.

(4) A student has the same entitlements to compensation as a worker.

(5) For the entitlements of a student to compensation, all the provisions of the Act under which entitlements are decided apply to the student in the same way as they would apply to a worker including, for example—

- the provisions of chapter 3 (Compensation)
- the provisions of chapter 7 (Medical Assessment Tribunals)
- the provisions of chapter 9 (Reviews and Appeals).

(6) However, insurance cover provided under a contract of insurance under this section is limited to compensation under chapter 3, parts 9 and 10¹⁷ of the Act.

(7) Also, the contract does not cover payment of damages for injury sustained by the student.

(8) WorkCover has a liability under a contract of insurance entered into under this section only if the premium assessed for the contract has been paid in full.

36 Insurance of industry placement students

(1) In this section—

“college” has the meaning given in the *Vocational Education and Training (Industry Placement) Act 1992*, section 4.

16 Chapter 1 (Preliminary), part 4 (Basic concepts), division 6 (Injuries and impairment), subdivision 2 (Injury) and subdivision 3 (When injury arises out of, or in the course of, employment) of the Act

17 Chapter 3 (Compensation), part 9 (Entitlement to compensation for permanent impairment) and part 10 (Compensation on worker’s death) of the Act

“industry placement” has the meaning given in the *Vocational Education and Training (Industry Placement) Act 1992*, section 8, but does not include a paid industry placement.

“industry placement place” means a place where industry placement is, or is to be, provided for a student.

“student” has the meaning given in the *Vocational Education and Training (Industry Placement) Act 1992*, section 4.

(2) WorkCover may enter into a contract of insurance with a college to insure the college against liability for compensation for injury to a student arising out of an industry placement.

(3) For this section, when deciding whether an injury arises out of, or in the course of, industry placement, chapter 1, part 4, division 6, subdivisions 2 and 3¹⁸ of the Act apply as if

- (a) the student were a worker; and
- (b) industry placement were the employment; and
- (c) the industry placement place were the place of employment; and
- (d) the college were the employer.

(4) A student has the same entitlements to compensation as a worker.

(5) For the entitlements of a student to compensation, all the provisions of the Act under which entitlements are decided apply to the student in the same way as they would apply to a worker including, for example—

- the provisions of chapter 3 (Compensation)
- the provisions of chapter 7 (Medical Assessment Tribunals)
- the provisions of chapter 9 (Reviews and Appeals).

(6) However, insurance cover provided under a contract of insurance under this section is limited to compensation under chapter 3, parts 9 and 10¹⁹ of the Act.

(7) Also, the contract does not cover payment of damages for injury sustained by the student.

18 Chapter 1 (Preliminary), part 4 (Basic concepts), division 6 (Injuries and impairment), subdivision 2 (Injury) and subdivision 3 (When injury arises out of, or in the course of, employment) of the Act

19 Chapter 3 (Compensation), part 9 (Entitlement to compensation for permanent impairment) and part 10 (Compensation on worker’s death) of the Act

(8) WorkCover has a liability under a contract of insurance entered into under this section only if the premium assessed for the contract has been paid in full.

Division 2—Eligible persons

37 Proposal for contract of insurance—Act, s 26

For section 26 of the Act, an eligible person is taken to express a wish to enter into a contract of insurance with WorkCover by lodging a fully completed and signed proposal in the approved form with WorkCover.

38 Documents to be kept by eligible person

(1) This section applies if WorkCover has entered into a contract of insurance for chapter 1, part 4, division 3, subdivision 4²⁰ of the Act with an eligible person.

(2) The eligible person must keep documents showing the remuneration or other benefit for performing work, or providing services, that the eligible person has received as an eligible person.

(3) If the eligible person applies for weekly payments of compensation under chapter 3, part 8, division 4, subdivision 3A or division 5, subdivision 2²¹ of the Act but cannot substantiate remuneration or other benefit received, WorkCover may pay an amount WorkCover considers is reasonable.

20 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 4 (Eligible persons) of the Act

21 Chapter 3 (Compensation), part 8 (Weekly payment of compensation), division 4 (Entitlement for total incapacity), subdivision 3A (Eligible persons) or division 5 (Entitlement for partial incapacity), subdivision 2 (Eligible persons) of the Act

Division 3—Other persons**39 Contracts of insurance for other persons**

(1) This section applies if a contract of insurance for chapter 1, part 4, division 3, subdivision 5²² of the Act provides for a matter to be decided by a medical assessment tribunal in accordance with chapter 7 of the Act or for an appeal to a court in accordance with chapter 9 of the Act.

(2) The provisions of the Act apply and jurisdiction is conferred on the tribunal or court to hear and decide the matter.

Division 4—Contracts of insurance generally**40 Entitlements of persons mentioned in ch 1, pt 4, div 3, subdivs 1, 2 and 4**

For the entitlements of a person mentioned in chapter 1, part 4, division 3, subdivision 1, 2 or 4²³ of the Act to compensation, all the provisions of the Act apply to the person in the same way as they would apply to a worker including, for example—

- the provisions of chapter 7 (Medical Assessment Tribunals)
- the provisions of chapter 9 (Reviews and Appeals).

41 WorkCover not liable if premium not paid

WorkCover is not liable under a contract of insurance under chapter 1, part 4, division 3 of the Act if the premium for the contract has not been paid in full to WorkCover on or before the due date.

22 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 5 (Other persons) of the Act

23 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 1 (Volunteers etc.), 2 (Persons performing community service etc.) or 4 (Eligible persons) of the Act

42 Duty to report injury

(1) This section applies if a person who is entitled to compensation under chapter 1, part 4, division 3 of the Act and is covered by a contract of insurance sustains an injury for which compensation may be payable.

(2) However, this section does not apply to an eligible person.

(3) The person with whom WorkCover has entered into the contract must complete a report in the approved form and send it to the nearest office of WorkCover.

(4) The report must be sent immediately after the first of the following happens—

- (a) the person with whom WorkCover has entered into the contract knows the injury has been sustained;
- (b) the person covered by the contract reports the injury to the person with whom WorkCover has entered into the contract;
- (c) the person with whom WorkCover has entered into the contract receives WorkCover's written request for a report.

(5) If the person with whom WorkCover has entered into the contract fails to comply with subsection (3) within 10 days after any of the circumstances mentioned in subsection (4), the person commits an offence, unless the person has a reasonable excuse.

Maximum penalty—20 penalty units.

PART 4—COMPENSATION

Division 1—Calculation of NWE

43 Calculation of NWE

Normal weekly earnings of a worker from employment are to be calculated under this division.

44 What amounts may or may not be taken into account

(1) Amounts paid to the worker by way of overtime, higher duties, penalties and allowances (other than amounts mentioned in subsection (2)) that are of a regular nature, required by an employer and that would have continued if not for the injury may be taken into account.

(2) Amounts mentioned in the Act, schedule 3, definition “wages”, paragraphs (a) to (d) are not to be taken into account.

45 NWE if impracticable to calculate rate of worker’s remuneration

(1) This section applies if it is impracticable, at the date of injury to the worker, to calculate the rate of the worker’s remuneration because of—

- (a) the period of time for which a worker has been employed; or
- (b) the terms of the worker’s employment.

(2) Regard must be had to—

- (a) the normal weekly earnings during the 12 months immediately before the date of injury of a person in the same grade, employed in the same work, by the same employer, as that of the worker; or
- (b) if there is no such person—the normal weekly earnings of a person in the same grade, employed in the same class of employment, and in the same district as that of the worker.

46 NWE if worker worked for 2 or more employers

(1) This section applies if a worker has worked under concurrent contracts of service with 2 or more employers, under which the worker has worked at 1 time for 1 employer and at another time for another of the employers.

(2) The worker’s normal weekly earnings are to be calculated as if earnings under all the contracts were earnings in the employment of the employer for whom the worker was working when the injury was sustained.

47 NWE if WorkCover considers calculation unfair

(1) This section applies if WorkCover considers that the calculation of normal weekly earnings under this division would be unfair.

(2) The normal weekly earnings may be calculated in the way WorkCover considers to be fair, and the calculation under this subsection is taken to be the normal weekly earnings of the worker.

Division 2—Compensation application and other procedures

48 Application for compensation

For section 159(3)(b)²⁴ of the Act, a claimant must give WorkCover, to the extent that WorkCover reasonably requires—

- (a) proof of injury and its cause; and
- (b) proof of the nature, extent and duration of incapacity resulting from the injury; and
- (c) if the injury is, or results in, the death of a worker—proof of—
 - (i) the worker's death; and
 - (ii) the identity of the worker; and
 - (iii) the relationship to the worker and dependency of persons claiming to be the worker's dependants.

49 Doctor's certificate

(1) The doctor's certificate required by section 159(3)(a) of the Act to accompany an application for compensation must be in the approved form.

(2) However, if a worker sustains an injury in another State or country, WorkCover must accept from the doctor who attends the worker a manuscript certificate that is substantially to the effect of the approved form.

(3) A doctor attending a worker who has sustained an injury must give WorkCover a detailed report on the worker's condition within 10 days after receiving Workcover's request to do so.

(4) The fee payable to the doctor for the report is an amount accepted by WorkCover to be reasonable, having regard to the relevant table of costs.

24 Section 159 (Applying for compensation) of the Act

50 If doctor not available

(1) This section applies if a claimant does not lodge a medical certificate with an application for compensation because a doctor was not available to attend the claimant.

(2) The claimant must complete and lodge with WorkCover a declaration in the approved form.

(3) For a non-fatal injury, the declaration—

- (a) can be accepted by WorkCover only once for injury to a claimant in any 1 event; and
- (b) is acceptable proof of incapacity of a claimant for not more than 3 days.

51 Examination of claimant or worker—Act, ss 162 and 447

(1) For sections 162 and 447²⁵ of the Act, a personal examination must be requested in writing to the claimant or worker.

(2) The request must specify—

- (a) the name of the doctor or other registered person, who is not employed by WorkCover under a contract of service, engaged to make the examination; and
- (b) if the doctor is a specialist—the field of specialty; and
- (c) the day, time and place when and where the examination is to be made.

(3) A doctor or other registered person who makes a personal examination of a claimant or worker must give WorkCover, within 10 days after the examination—

- (a) a written report on the examination; and
- (b) an itemised account for the examination.

(4) Fees payable to a doctor or other registered person for a personal examination of a claimant or worker—

- (a) are payable by WorkCover; and

25 Sections 162 (Examination by registered person) and 447 (Power of tribunal to examine worker) of the Act

- (b) are payable for—
 - (i) making the examination; and
 - (ii) giving a report to WorkCover; and
- (c) are the costs accepted by WorkCover to be reasonable, having regard to the relevant table of costs.

52 Payment for treatment arranged by employer other than self-insurer

(1) An employer, other than a self-insurer, may, with WorkCover's consent, make an arrangement or agreement, on behalf of WorkCover, with a doctor, hospital or institution to provide—

- (a) medical treatment; or
- (b) hospitalisation; or
- (c) medical aid;

to a worker who has sustained injury.

(2) WorkCover may ratify an arrangement or agreement made by an employer without WorkCover's consent if WorkCover is satisfied that—

- (a) the case was one of emergency; and
- (b) in the interests of the worker, it was necessary to take immediate action.

(3) WorkCover is liable to pay the reasonable expenses of medical treatment, hospitalisation or medical aid provided to the worker under the arrangement or agreement.

53 Maximum liability for cost of hospitalisation—Act, s 236

For section 236²⁶ of the Act, the maximum amount that WorkCover is liable to pay for hospitalisation of a worker is \$10 000.

54 Special medical treatment, hospitalisation or medical aid

(1) This section applies if WorkCover considers that the injury sustained by a worker would require—

26 Section 236 (Maximum liability for cost of hospitalisation) of the Act

- (a) special medical treatment; or
- (b) special hospitalisation; or
- (c) special medical aid.

(2) WorkCover may make an arrangement or agreement with a doctor, hospital or institution to provide the worker with the special medical treatment, hospitalisation or medical aid.

(3) For special hospitalisation, WorkCover may make the arrangement or agreement only to the extent specified in section 234²⁷ of the Act.

(4) WorkCover is liable to pay the cost of the special medical treatment, hospitalisation or medical aid provided to the worker under the arrangement or agreement.

(5) However, the maximum amount that WorkCover is liable to pay for special hospitalisation is \$10 000.

Division 3—Entitlement to compensation for permanent impairment

55 Table of injuries

(1) The table of injuries is set out in schedule 2.

(2) The table of injuries, parts 1, 2, 4 and 6 must be read in conjunction with the relevant provisions of the AMA guide.

(3) The methods that must be used in assessing the degree of permanent impairment resulting from an injury mentioned in part 1, 2, 4 or 6 are the methods stated in the AMA guide.

(4) However, not every injury a worker may sustain is mentioned in the table of injuries and, if a worker sustains permanent impairment from an injury that is not mentioned in the table of injuries (other than in part 3 or 5), the AMA guide must be used for assessing the degree of permanent impairment resulting from the injury.

(5) The table of injuries, part 3 must be read in conjunction with the ophthalmologists guide (for vision injuries) and the hearing loss tables (for hearing injuries).

27 Section 234 (Extent of liability for period of hospitalisation) of the Act

(6) The methods that must be used in assessing the degree of permanent impairment resulting from an injury mentioned in the table of injuries, part 3 are the methods stated in the ophthalmologists guide or hearing loss tables.

(7) If there is an inconsistency between the table of injuries and the AMA guide, the ophthalmologists guide or the hearing loss tables, the table of injuries prevails to the extent of the inconsistency.

(8) For subsection (2), a provision of the AMA guide is a relevant provision of the guide for a part of the table of injuries if it is mentioned in the part as a relevant provision for the part.

56 Assessing degree of permanent impairment from multiple injuries using the table of injuries

(1) This section applies if a worker sustains permanent impairment from multiple injuries sustained in 1 event.

(2) The degree of permanent impairment for each injury is assessed separately and lump sum compensation is decided accordingly.

Example—

A worker sustains a fractured pelvis and a fractured wrist in the same event. The degree of permanent impairment resulting from each injury is assessed separately in the usual way under the table of injuries.

(3) However, for multiple injuries to a single limb, the degree of permanent impairment sustained by the worker in relation to the limb is assessed by using the combined values chart in the AMA guide, unless the guide specifies otherwise.

Example—

A worker sustains injuries to the worker's right wrist and right elbow and a crush injury to the worker's left hand. The degree of permanent impairment resulting from the injuries to the right arm is assessed by using the combined values chart in the AMA guide. The degree of permanent impairment resulting from the injury to the left hand is assessed in the usual way under the table of injuries.

(4) Also, if a worker sustains multiple injuries of a kind mentioned in the table of injuries, part 4 in 1 event, the degree of permanent impairment sustained by the worker in relation to the injuries is assessed by using the combined values chart in the AMA guide.

57 Assessment for industrial deafness—Act, s 197

(1) This section sets out the way the degree of permanent impairment for industrial deafness must be assessed for section 197²⁸ of the Act.

(2) The worker must undergo an audiometric test for hearing conducted by an audiologist.

(3) The test must be preceded by a period of quiet of at least 8 hours.

(4) For air conduction testing, the test must comply with Australian Standard AS1269 ‘SAA Hearing Conservation Code’, rules 5.6.3.2. and 5.6.3.4(c).

(5) The worker’s hearing levels must be determined separately for the left and right ears at audiometric test frequencies 500, 1 000, 1 500, 2 000, 3 000 and 4 000 Hz with an audiometer complying with Australian Standard AS2586.

(6) The percentage loss of hearing is to be calculated by using the binaural tables and adjusted, if required, under the presbycusis correction table.

58 Calculation of WRI—Act, s 201

(1) For section 201²⁹ of the Act, a worker’s WRI is the percentage calculated using the following formula—

$$\frac{\text{LSPI} \times 100}{\text{MSC}}$$

(2) In this section—

“**LSPI**” means the lump sum compensation payable under the table of injuries for the degree of permanent impairment for the injury.

“**MSC**” means maximum statutory compensation under chapter 3, part 6³⁰ of the Act.

Example—

If a worker loses a thumb, the lump sum compensation payable under the table of injuries is \$43 200. The maximum statutory compensation is \$150 000. So, the worker’s WRI is 28.8% [(43 200 x 100) ÷ 150 000].

28 Section 197 (Assessment of permanent impairment) of the Act

29 Section 201 (Calculation of WRI) of the Act

30 Chapter 3 (Compensation), part 6 (Maximum statutory compensation) of the Act

59 Additional lump sum compensation for certain workers—Act, s 210

The additional lump sum compensation payable for certain workers is set out in schedule 3.

60 Additional lump sum compensation for gratuitous care—Act, s 211

(1) The additional lump sum compensation payable for gratuitous care is set out in schedule 4.

(2) For section 211(5)³¹ of the Act, the assessment report of an occupational therapist must state whether, in the relationship between the worker and the other person, the day-to-day care—

- (a) was provided to the worker before the worker sustained the impairment; and
- (b) would ordinarily be provided in the worker's home; and
- (c) is likely to continue to be provided in the worker's home.

(3) The method of assessing a worker's level of dependency is the method stated in the modified barthel index.

(4) In deciding the amount of the worker's entitlement to additional compensation, WorkCover must have regard to the information in the report.

PART 5—REHABILITATION*Division 1—Caring allowance***61 Further information required in occupational therapist's report—Act, s 241**

(1) An occupational therapist's assessment report must contain the information mentioned in section 60(2).

31 Section 211 (Additional lump sum compensation for gratuitous care) of the Act

(2) In paying the caring allowance, WorkCover must have regard to the information in the report.

62 Extent of liability for caring allowance—Act, s 242

(1) WorkCover must decide the number of hours of care required for a worker having regard to the occupational therapist's report and the graduated scale in schedule 5.

(2) The method of assessing a worker's level of dependency is the method stated in the modified barthel index.

(3) The amount of the caring allowance—

(a) must be decided having regard to the number of hours of care required; and

(b) must be paid at an hourly rate equal to the carer pension rate divided by 35.

(4) In subsection (3)(b)—

“carer pension rate” means the weekly amount of the maximum single carer pension rate payable from time to time under a Commonwealth law but does not include an amount for allowances, for example, rent assistance or family payment.

Division 2—Workplace rehabilitation policy and procedures

63 Reporting requirement for review of workplace rehabilitation policy and procedures

For section 244(4)³² of the Act, an employer must, within 30 days after completing a review of the employer's workplace rehabilitation policy and procedures, give WorkCover written evidence, in the approved form, that the review has been completed.

32 Section 244 (Employer's obligation to have workplace rehabilitation policy and procedures) of the Act

Division 3—Standard for rehabilitation

64 Who this division applies to

This division applies to anyone who is required, under chapter 4, parts 3 and 4³³ of the Act, to provide or manage the rehabilitation of workers.

65 Definition for div 3

In this division—

“**rehabilitation plan**” means a written plan outlining the rehabilitation objectives and the steps required to achieve the objectives.

66 Standard for rehabilitation

For section 245³⁴ of the Act, the standard of rehabilitation must be in accordance with this division.

67 Doctor’s approval

Approval of a worker’s treating doctor must be obtained and documented for all rehabilitation plans, including amendments to plans.

68 Worker’s file

A file must be kept for each worker undertaking rehabilitation and must contain copies of all relevant documentation, correspondence and accounts.

69 Rehabilitation plan

(1) A rehabilitation plan must be developed for each worker undertaking rehabilitation.

(2) The plan must be consistent with the worker’s needs.

(3) The plan must be developed in consultation with the worker.

33 Chapter 4 (Injury management), part 3 (Responsibility for rehabilitation) and part 4 (Employer’s obligation for rehabilitation) of the Act

34 Section 245 (Employer’s obligation to assist or provide rehabilitation) of the Act

(4) The plan must at least contain the following matters—

- (a) clear and appropriate objectives with ways of achieving the objectives;
- (b) details of rehabilitation required to meet the objectives;
- (c) projected costs and time frames of rehabilitation;
- (d) review mechanisms and dates for review;
- (e) progress to date.

70 Case notes

(1) Accurate and objective case notes must be kept for each worker undertaking rehabilitation.

(2) Case notes must contain details of—

- (a) all communications between the worker, the rehabilitation coordinator and other relevant parties; and
- (b) actions and decisions; and
- (c) reasons for actions and decisions.

71 Early worker contact

A worker who sustains an injury and who requires rehabilitation must be contacted about rehabilitation as soon as practicable after the injury is sustained or is reported.

72 Rehabilitation

(1) Rehabilitation must be goal directed with timely and appropriate service provision having regard to—

- (a) the worker's injury; and
- (b) the objectives of the rehabilitation plan; and
- (c) the worker's rate of recovery.

(2) Strategies used in rehabilitation must be evaluated by the rehabilitation coordinator as the case progresses to monitor their effectiveness.

(3) Rehabilitation must focus on return to work.

(4) However, if the worker's injury is so severe that a return to work is precluded, rehabilitation must focus on maximising the worker's independent functioning.

(5) Duties assigned to a worker for a suitable duties program must be meaningful and have regard to the objective of the worker's rehabilitation.

(6) The rehabilitation coordinator must ensure rehabilitation for a worker is coordinated with and understood by line managers, supervisors and co-workers.

(7) A worker must be treated with appropriate respect and equity.

73 Confidentiality

(1) Information obtained during rehabilitation must be treated with sensitivity and confidentiality by all parties.

(2) If it is necessary to obtain or release information associated with the worker's rehabilitation, the worker's authority to obtain or release the information must be obtained.

(3) The worker's authority is not required for the release of information to WorkCover.

PART 6—DAMAGES

74 Notice of claim for damages—Act, s 280

(1) A notice of claim must be made in the approved form and include the following particulars³⁵—

- (a) full particulars of the claimant, including—
 - (i) full name and any other known names; and
 - (ii) if the claimant is not the worker—the worker's full name; and
 - (iii) residential address; and

³⁵ See also the Act, section 280A(2) (Noncompliance with s 280 and urgent proceedings).

- (iv) date of birth; and
 - (v) gender; and
 - (vi) usual occupation and, if that differs from the nature of employment at the time of the event, the nature of the employment at the time of the event; and
 - (vii) the name and address of every employer of the worker at the time of the event;
- (b) full particulars of the event, including—
- (i) the date, time and place of the event; and
 - (ii) a description of the facts, as the claimant understands or recalls them to be, of the circumstances surrounding the event; and
 - (iii) names and addresses of all witnesses to the event, and their relationship, if any, to the worker; and
 - (iv) name and address of any person on behalf of the claimant's employer to whom the claimant reported the event and their employment details; and
 - (v) full particulars of the negligence alleged against the claimant's employer and any other party on which the claim is based; and
 - (vi) whether, and to what extent, liability expressed as a percentage is admitted for the injury and, if another party is involved, the liability expressed as a percentage that the claimant holds the other party responsible; and
 - (vii) if another party is involved—details of the notice given to the party;
- (c) full particulars of the nature and extent of—
- (i) all injuries alleged to have been sustained by the claimant because of the event; and
 - (ii) the degree of permanent impairment that the claimant alleges has resulted from the injuries; and
 - (iii) the amount of damages sought under each head of damage claimed by the claimant and the method of calculating each amount; and
 - (iv) how the claimant is presently affected by the injuries;

- (d) the name and address of each hospital at which the claimant has been treated for the injury, and the name and address of each doctor by whom the claimant has been treated for the injury;
- (e) the name and address of each provider of treatment or rehabilitation services who has made an assessment of, or provided treatment or rehabilitation services for, permanent impairment arising from the injury;
- (f) all personal injuries, illnesses and impairments of a medical, psychiatric or psychological nature sustained by the claimant either before or after the event that may affect the extent of the permanent impairment resulting from the injury to which the claim relates, or may affect the amount of damages in another way;
- (g) all personal injuries, illnesses and impairments of a medical, psychiatric or psychological nature sustained by the claimant either before or after the event for which the claimant has claimed damages, compensation or benefits, the name and address of any person against whom a claim for damages or compensation was made and, if an insurer was involved, the name and address of the insurer;
- (h) the name and address of each hospital at which the claimant has been treated for an injury, illness or impairment mentioned in paragraph (f) or (g), and the name and address of each doctor by whom the claimant has been treated for the injury, illness or impairment;
- (i) all steps taken by the worker to mitigate their loss;
- (j) if the claimant claims damages for diminished income earning capacity—particulars of the claimant's employment during the 3 years immediately before and since the event including—
 - (i) the name and address of each of the claimant's employers; and
 - (ii) the period of employment by each employer; and
 - (iii) the capacity in which the claimant was employed by each employer; and
 - (iv) the claimant's gross and net (after tax) earnings for each period of employment; and

- (v) the periods during which the claimant was in receipt of payments from the Department of Social Security (Cwlth); and
- (vi) the periods during which the claimant received no income, and the reasons why the claimant was not receiving any income.

(2) A notice of claim relating to an injury causing death must contain the following additional particulars (if relevant)—

- (a) if the claimant is the deceased worker's spouse—
 - (i) the date of marriage or the date on which the de facto relationship started; and
 - (ii) the place of marriage or the residential address where the de facto relationship started; and
 - (iii) the claimant's net (after tax) weekly income before and after the worker's death; and
 - (iv) the age to which the claimant intended to work and the basis of the claimant's future employment i.e. whether full time or part time; and
 - (v) details of any health problems that the claimant currently has; and
 - (vi) the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount; and
 - (vii) the expected date of birth of a posthumous child; and
 - (viii) details of remarriage or start of a marriage-like relationship;
- (b) if the claimant is not the deceased worker's spouse—
 - (i) the claimant's relationship to the deceased worker; and
 - (ii) the claimant's net (after tax) weekly earnings; and
 - (iii) the age to which the claimant would have been dependent on the deceased worker and the basis of the dependency; and
 - (iv) details of any health problems that the claimant currently has; and

- (v) the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount.

74A Notice of claim and urgent proceedings—Act, s 280A

(1) This section applies if the claimant alleges an urgent need to start a proceeding for damages despite noncompliance with section 280 of the Act.

(2) For section 280A(4) of the Act, the claimant's notice of claim must be faxed to—

- (a) if the worker's employer is not a self-insurer—WorkCover at WorkCover's registered office; or
- (b) if the worker's employer is a self-insurer—the self-insurer at the self-insurer's registered office.

(3) The claimant's notice of claim must include a cover page stating—

- (a) the sender's name and address; and
- (b) the total number of pages sent, including the cover page; and
- (c) the fax number from which the notice is sent; and
- (d) the date of the transmission; and
- (e) the name and fax number of the person to whom the fax is being sent; and
- (f) the name and phone number of a person to contact if there is a problem with the transmission; and
- (g) a statement that the transmission is for the giving of the notice of claim under section 280A(4) of the Act.

(4) If there is a dispute about the giving of the notice of claim under section 280A(4) of the Act, the transmission advice generated by the sender's fax machine confirming the transmission was successful must be included as an exhibit to any affidavit of service.

PART 7—COSTS

Division 1—Proceeding before industrial magistrate

75 Costs—proceeding before industrial magistrate

(1) The costs of a proceeding before an industrial magistrate are in the discretion of the magistrate.

(2) However, if the magistrate allows costs—

(a) for costs in relation to counsel's or solicitor's fees—

(i) the costs are to be under the *Uniform Civil Procedure Rules 1999*, schedule 3;³⁶ or

(ii) if, because of—

(A) the work involved; or

(B) the importance, difficulty or complexity of the matter to which the proceedings relate;

the industrial magistrate considers the amount of costs provided for under subparagraph (i) are inadequate remuneration, the magistrate may allow costs (in total or in relation to any item) in an amount up to 1.5 times the amount provided for under subparagraph (i) (in total or in relation to that item); and

(b) for costs in relation to witnesses' fees and expenses—the costs are to be under the *Uniform Civil Procedure (Fees) Regulation 1999*, part 4;³⁷ and

(c) for costs in relation to bailiff's fees—the costs are to be under the *Uniform Civil Procedure (Fees) Regulation 1999*, schedule 3, part 2.³⁸

36 *Uniform Civil Procedure Rules 1999*, schedule 3 (Scale of costs—Magistrates Courts)

37 *Uniform Civil Procedure (Fees) Regulation 1999*, part 4 (Allowances for witnesses and interpreters)

38 *Uniform Civil Procedure (Fees) Regulation 1999*, schedule 3 (Magistrates Courts fees), part 2 (Bailiff's fees) was renumbered as schedule 2, part 2—now see *Justice Legislation (Variation of Fees and Costs) Regulation 2001*, section 22.

(3) Subsection (4) applies if—

- (a) WorkCover is required to pay costs in a hearing in relation to a witness who is a doctor or otherwise is of a professional description; and
- (b) the amount of fees and expenses payable in relation to the witness by the party that called the witness is more than the amount of costs allowed by the industrial magistrate.

(4) WorkCover may, on the application of the party that called the witness, pay an additional amount on account of the costs that WorkCover accepts as reasonable, having regard to the subject matter of the hearing.

Division 2—Claim for damages

76 Who this division applies to

This division applies only to a claimant who is—

- (a) a worker whose WRI is 20% or more; or
- (b) a dependant.

77 Definition for div 2

In this division—

“**net damages**” means damages recovered less compensation paid by WorkCover.

78 Costs before proceeding started

(1) This section prescribes the legal professional costs of a claim before a proceeding is started.

(2) If a claimant recovers at least \$150 000 net damages, the costs are—

- (a) if the claim is settled—
 - (i) without holding a compulsory conference—120% of the amount in schedule 6, column A; or
 - (ii) after a compulsory conference is held—the amounts in schedule 6, columns A and B; and

- (b) for investigation of liability by an expert—the amount in schedule 6, column C; and
- (c) for an application to the court—the amount in schedule 6, column D.

(3) If a claimant recovers net damages of \$50 000 or more but less than \$150 000, the costs are 85% of the amount under subsection (2).

(4) If a claimant recovers less than \$50 000 net damages, the costs are 85% of the amount calculated under subsection (2) multiplied by the proportion that the net damages bear to \$50 000.

Example of subsection (4)—

If the net damages recovered are \$30 000, the costs are (85% of the amount calculated under subsection (2)) $\times \frac{3}{5}$.

(5) However, if a court in the proceeding awards the payment of solicitor-client costs, the costs recoverable under subsections (2), (3) and (4) are multiplied by 120%.

79 Costs after proceeding started

(1) This section prescribes the legal professional costs of a claim after a proceeding is started.

(2) The costs are chargeable under the relevant court scale of costs.

(3) However, the costs under subsection (2) do not include—

- (a) the cost of work performed before the proceeding is started; or
- (b) the cost of work performed before the proceeding is started that is performed again after the proceeding is started.

80 Outlays

(1) In addition to legal professional costs, the following outlays incurred by the claimant are allowed—

- (a) 1 hospital report fee for each hospital that provided treatment for the worker's injury;
- (b) 1 report fee for each doctor in general practice who provided treatment for the worker's injury;

- (c) 1 medical specialist's report fee for each medical discipline reasonably relevant and necessary for the understanding of the worker's injury;
 - (d) 1 report fee of an expert investigating liability, of not more than \$1 000, less any proportion of the fee agreed to be paid by WorkCover;
 - (e) Australian Taxation Office or tax agents' fees for supplying copies of income tax returns;
 - (f) fees charged by the claimant's previous employers for giving information necessary for the claimant to complete the notice of claim, but not more than \$50 for each employer;
 - (g) fees charged by a mediator in an amount previously agreed to by WorkCover;
 - (h) filing fees or other necessary charges incurred in relation to an application to the court before a proceeding is started;
 - (i) reasonable fees for sundry items properly incurred, other than photocopying costs.
- (2) The fees—
- (a) are allowable only for reports disclosed before the start of proceedings; and
 - (b) for subsection (1)(a) to (c)—are payable according to the recommended Australian Medical Association scale of fees.

PART 8—REASONS FOR DECISIONS

81 Reasons for decisions must address certain matters—Act, s 489(4)

- (1) For section 489(4) of the Act, the reasons must—
- (a) cite the provision of the Act under which the decision is made; and
 - (b) state the evidence considered for the decision; and
 - (c) state the evidence that was accepted or rejected for the decision and why it was accepted or rejected; and

- (d) state the conclusions drawn from the evidence; and
- (e) disclose the link between the evidence, the conclusions and the relevant provision of the Act.

(2) The reasons must also clearly state the decision made and be written in plain English.

PART 9—AMOUNT OF CALCULATION OF LIABILITY FOR SELF-INSURERS

Division 1—Outstanding liability

Subdivision 1—Purpose and application of div 1

82 Purpose of div 1

This division sets out the process for the calculation of an amount for a self-insurer's outstanding liability for the Act, section 116.³⁹

83 Application of div 1

This division applies to the following employers—

- (a) an employer who was licensed as a self-insurer immediately before 3 March 1999 (a “**current self-insurer**”);
- (b) an employer who lodged an application to be licensed as a self-insurer on or before 3 March 1999 (a “**current applicant**”);
- (c) an employer who applies to be licensed as a self-insurer after 3 March 1999 (a “**new applicant**”).

³⁹ The Act, section 116 (Self-insurer replaces WorkCover in liability for injury)

Subdivision 2—Calculation

84 Appointment of actuary for calculation

WorkCover and the employer must each appoint an actuary to calculate an amount for the outstanding liability.

85 Calculation

(1) The calculation must—

- (a) be prepared under the actuarial standard; and
- (b) apply a central estimate of the outstanding liability; and
- (c) as far as practicable, be based on the employer's claims experience from claims incurred before the employer becomes or became a self-insurer; and
- (d) apply the risk free rate of return; and
- (e) include claims administration expenses of 7% of the outstanding liability; and
- (f) not include a prudential margin.

(2) For a new applicant, the calculation must be based on data as at the last day (the “**assessment day**”) of the financial quarter immediately before the day the application for self-insurance is lodged.

(3) For a current self-insurer or a current applicant, the calculation must be based on data as at the last day (also the “**assessment day**”) of the last financial quarter for which data is available—

- (a) 3 months before the day the application for renewal of self-insurance is lodged; or
- (b) if the self-insurer or applicant decides to assume the outstanding liability before lodging the application for renewal, on the day WorkCover receives written notice of the decision.

86 WorkCover to give actuaries information

WorkCover must give the actuaries the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 87(3).

87 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

- (a) be prepared under the actuarial standard; and
- (b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—
 - (i) the average amount of claims for compensation against the employer; and
 - (ii) the average amount of claims for damages against the employer; and
 - (iii) claims anticipated to have been incurred by the employer for which no formal claim has been lodged; and
 - (iv) the frequency of claims for compensation against the employer; and
 - (v) the frequency of claims for damages against the employer; and
 - (vi) the net amount of the claims after allowing for future inflation (“**inflated value**”); and
 - (vii) the net present value of the inflated value after allowing for income from assets set aside by the employer to pay the outstanding liability; and
 - (viii) the rate of inflation used; and
- (c) state the following about the data used in the calculation—
 - (i) the nature of the data;
 - (ii) the actuary’s assessment of its accuracy;
 - (iii) how the actuary interpreted the data; and
- (d) state the actuarial model used in the calculation; and
- (e) state the results of the calculation; and
- (f) state the actuary’s confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports—

- (a) for a new applicant—within 35 days after the day the application for self-insurance is lodged; or
- (b) for a current self-insurer or a current applicant—
 - (i) no later than 2 months before the day the application for renewal of self-insurance is lodged; or
 - (ii) if the self-insurer or applicant decided to assume the outstanding liability before lodging the application for renewal, no later than 35 days after the day WorkCover received written notice of the decision.

88 Summary report

(1) The actuaries must jointly prepare a summary report that—

- (a) includes the individual actuarial reports; and
- (b) states how the individual reports agree or differ.

(2) The actuaries must give the completed summary report to WorkCover and the employer—

- (a) for a new applicant—within 2 months after the day the application for self-insurance is lodged; or
- (b) for a current self-insurer or a current applicant—
 - (i) no later than 35 days before the day the application for renewal of self-insurance is lodged; or
 - (ii) if the self-insurer or applicant decided to assume the outstanding liability before lodging the application for renewal, no later than 2 months after the day WorkCover received written notice of the decision.

89 Agreement on calculation

WorkCover and the employer may agree on the calculation having regard to the summary report.

90 Reference to actuarial arbiter if no agreement

If WorkCover and the employer can not agree on the calculation, WorkCover must refer the summary report to the arbiter for decision within 14 days after WorkCover is given the summary report.

91 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by WorkCover and the employer in equal amounts.

92 Payment of amount for outstanding liability—new applicant

(1) For a new applicant, the amount WorkCover must pay for the employer's outstanding liability is the amount agreed to by WorkCover and the employer (the "**agreed amount**") or, if there is no agreement, the amount decided by the arbiter (the "**decided amount**").

(2) WorkCover must pay the employer—

- (a) 75% of the agreed or decided amount on the day the licence commences; and
- (b) the balance within 1 month after the day the licence commences.

(3) The agreed or decided amount paid to the employer must be adjusted by WorkCover's actuary to take into account—

- (a) compensation and damages payments made between the assessment day and the day the employer becomes liable for the employer's outstanding liability; and
- (b) claims lodged against the employer between the assessment day and the day the employer becomes liable for the employer's outstanding liability.

93 Election by current self-insurer or current applicant about payment for outstanding liability

(1) This section applies if the employer is a current self-insurer or a current applicant.

(2) The employer may, by written notice given to WorkCover, elect to accept—

- (a) payment of an amount for the outstanding liability unconditionally; or
- (b) an interim payment of an amount on account of the outstanding liability.

(3) The employer must make the election within 7 days after—

- (a) WorkCover and the employer agree on the calculation; or

- (b) if there is no agreement, the employer receives the statement of the arbiter's decision about the calculation.

(4) If the employer elects to accept payment of an amount under subsection (2)(a), the amount WorkCover must pay for the employer's outstanding liability is the total of—

- (a) the agreed or decided calculation; and
(b) an amount equal to 5% of the agreed or decided central estimate.

(5) If the employer accepts payment of an amount under subsection (2)(a), no further amount is payable for the outstanding liability.

(6) If the employer elects to accept an interim payment under subsection (2)(b), an amount for the outstanding liability is recalculated under subdivision 3.

(7) In this section—

“agreed” means agreed to by WorkCover and the employer.

“decided” means decided by the arbiter.

94 Payment of amount for, or on account of, outstanding liability—current self-insurer and current applicant

(1) For a current self-insurer or a current applicant, WorkCover must pay the employer, for or on account of the outstanding liability—

- (a) 75% of the amount mentioned in section 93(2)(a) or (b) on the day the licence is renewed; and
(b) the balance within 1 month after the day the licence is renewed.

(2) However, if the employer decided to assume the outstanding liability before lodging the application for renewal, WorkCover must pay the whole of the amount—

- (a) within 3 months after the day WorkCover received written notice of the decision; or
(b) on a later day agreed to by WorkCover and the employer.

(3) The amount paid to the employer must be adjusted by WorkCover's actuary to take into account—

- (a) compensation and damages payments made between the assessment day and the day the employer becomes liable for the employer's outstanding liability; and

- (b) claims lodged against the employer between the assessment day and the day the employer becomes liable for the employer's outstanding liability.

95 Transfer of claims information

WorkCover must give the employer claims information in relation to the employer's outstanding liability—

- (a) for a new applicant—before the day the licence commences; or
- (b) for a current self-insurer or a current applicant—
 - (i) before the day the licence is renewed; or
 - (ii) if the self-insurer or applicant decided to assume the outstanding liability before lodging the application for renewal, no later than the day the whole of the amount mentioned in section 93(2)(a) or (b) is paid.

Subdivision 3—Recalculation

96 Purpose of sdiv 3

This subdivision sets out the process for the recalculation of an amount for a self-insurer's outstanding liability if the self-insurer has made an election under subdivision 2 to accept an interim payment on account of the outstanding liability.

97 Application of sdiv 3 for group employers

If the self-insurer is a group employer, this subdivision applies only in relation to—

- (a) the members of the group as at the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability; or
- (b) if the self-insurer applied, on or before the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability, for WorkCover's consent to change the group membership on the licence—the proposed members of the group as at that day.

98 Appointment of actuary for recalculation

At the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability, WorkCover and the self-insurer must each appoint an actuary to recalculate an amount for the outstanding liability.

99 Recalculation

(1) The recalculation must—

- (a) be prepared under the actuarial standard; and
- (b) apply a central estimate of the outstanding liability; and
- (c) as far as practicable, be based on the self-insurer's claims experience from claims incurred before the self-insurer became a self-insurer; and
- (d) apply the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2; and
- (e) include claims administration expenses of 7% of the outstanding liability; and
- (f) not include a prudential margin; and
- (g) have regard to compensation and damages payments made in relation to the liability between the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability and the end of 5 years after that day; and
- (h) exclude an amount for liability in relation to a change in the self-insurer's membership after the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

(2) The recalculation must be based on data as at the last day (the “**assessment day**”) of the last financial quarter for which data is available at the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

100 WorkCover to give actuaries information

WorkCover must give the actuaries the information necessary to enable the actuaries to complete the recalculation within the time mentioned in section 101(3).

101 Actuarial report

(1) After completing the recalculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

- (a) be prepared under the actuarial standard; and
- (b) clearly state the key assumptions made for the recalculation and how the assumptions have been derived, including—
 - (i) the average amount of claims for compensation against the self-insurer; and
 - (ii) the average amount of claims for damages against the self-insurer; and
 - (iii) claims anticipated to have been incurred by the self-insurer for which no formal claim has been lodged; and
 - (iv) the frequency of claims for compensation against the self-insurer; and
 - (v) the frequency of claims for damages against the self-insurer; and
 - (vi) the net amount of the claims after allowing for future inflation (“**inflated value**”); and
 - (vii) the net present value of the inflated value as calculated at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2; and
 - (viii) the rate of inflation used; and
- (c) state the following about the data used in the recalculation—
 - (i) the nature of the data;
 - (ii) the actuary’s assessment of its accuracy;
 - (iii) how the actuary interpreted the data; and
- (d) state the actuarial model used in the recalculation; and
- (e) state the results of the recalculation; and
- (f) state the actuary’s confidence in the results of the recalculation.

(3) The actuaries must complete the recalculations and the reports within 35 days after the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer’s outstanding liability.

102 Summary report

(1) The actuaries must jointly prepare a summary report that—

- (a) includes the individual actuarial reports; and
- (b) states how the individual reports agree or differ.

(2) The actuaries must give the completed summary report to WorkCover and the self-insurer within 2 months after the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

103 Agreement on recalculation

WorkCover and the self-insurer may agree on the recalculation having regard to the summary report.

104 Reference to actuarial arbiter if no agreement

If WorkCover and the self-insurer can not agree on the recalculation, WorkCover must refer the summary report to the actuarial arbiter for decision within 14 days after WorkCover is given the summary report.

105 Arbiter's costs

The arbiter's costs in deciding on the recalculation are to be paid by WorkCover and the self-insurer in equal amounts.

106 Payment of amount for recalculation

(1) If the amount agreed to by WorkCover and the self-insurer (the **“agreed amount”**) or, if there is no agreement, the amount decided by the arbiter (the **“decided amount”**), for the recalculation is more than the interim payment made under subdivision 2 on account of the outstanding liability—

- (a) the amount WorkCover must pay for the self-insurer's outstanding liability is the agreed or decided amount; and
- (b) WorkCover must pay the self-insurer—
 - (i) the difference between the interim payment and the amount for the outstanding liability; and

- (ii) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2.
- (2) If the agreed or decided amount is less than the interim payment—
- (a) the amount WorkCover must pay for the self-insurer's outstanding liability is—
 - (i) the interim payment; less
 - (ii) 30% of the difference between the interim payment and the agreed or decided amount; and
 - (b) the self-insurer must pay WorkCover—
 - (i) the difference between the interim payment and the amount for the outstanding liability; and
 - (ii) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2.
- (3) WorkCover or the self-insurer must pay the amount of the difference within 28 days after—
- (a) WorkCover and the self-insurer agree on the recalculation; or
 - (b) if there is no agreement, WorkCover or the self-insurer receives the statement of the arbiter's decision about the recalculation.
- (4) On payment of the amount, no further amount is payable for the outstanding liability.

Division 2—Total liability and residual liability

107 Purpose of div 2

This division sets out the process for the calculation of an amount for total liability for the Act, section 118A(1), (3), (5) or (7)⁴⁰ or residual

⁴⁰ The Act, section 118A (Consequences of change in self-insurer's membership)

liability for the Act, section 576(2), (4) or (6)⁴¹ because of a change in a self-insurer's membership.

108 Appointment of actuary

The party with whom the liability currently resides (the “**old insurer**”) and the party assuming liability (the “**new insurer**”) must each appoint an actuary to calculate an amount for the total or residual liability.

109 Calculation

(1) The calculation must—

- (a) be prepared under the actuarial standard; and
- (b) apply a central estimate of the total or residual liability; and
- (c) as far as practicable, be based on the claims experience of the employer or member of a group employer that is the subject of the transfer of liability; and
- (d) apply the risk free rate of return; and
- (e) include claims administration expenses of 7% of the total or residual liability; and
- (f) not include a prudential margin.

(2) The calculation must be based on data as at the last day (the “**assessment day**”) of the financial quarter immediately before—

- (a) for the calculation of total liability for the Act, section 118A(1), (3), (5) or (7)—the day the self-insurer applies to WorkCover under the Act, section 118 for a change in the group membership on the licence; or
- (b) for the calculation of residual liability for the Act, section 576(2), (4) or (6)—the relevant day mentioned in the Act, section 576(3), (5) or (7).⁴²

41 The Act, section 576 (Change in self-insurer's membership)

42 The Act, section 576 (Change in self-insurer's membership)

110 Parties to give actuaries information

The parties must give the actuaries, in the form approved by WorkCover, the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 111(3).

111 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

- (a) be prepared under the actuarial standard; and
- (b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—
 - (i) the average amount of claims for compensation against the employer or member; and
 - (ii) the average amount of claims for damages against the employer or member; and
 - (iii) claims anticipated to have been incurred by the employer or member for which no formal claim has been lodged; and
 - (iv) the frequency of claims for compensation against the employer or member; and
 - (v) the frequency of claims for damages against the employer or member; and
 - (vi) the net amount of the claims after allowing for future inflation (“**inflated value**”); and
 - (vii) the net present value of the inflated value after allowing for income from assets set aside by the employer or member to pay the total or residual liability; and
 - (viii) the rate of inflation used; and
- (c) state the following about the data used in the calculation—
 - (i) the nature of the data;
 - (ii) the actuary’s assessment of its accuracy;
 - (iii) how the actuary interpreted the data; and
- (d) state the actuarial model used in the calculation; and

- (e) state the results of the calculation; and
- (f) state the actuary's confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports within 35 days after WorkCover approves the application for the change in the self-insurer's membership (the “**consent day**”).

112 Summary report

(1) The actuaries must jointly prepare a summary report that—

- (a) includes the individual actuarial reports; and
- (b) states how the individual reports agree or differ.

(2) The actuaries must give the completed summary report to the parties within 2 months after the consent day.

113 Agreement on calculation

The parties may agree on the calculation having regard to the summary report.

114 Reference to actuarial arbiter if no agreement

If the parties can not agree on the calculation, the party with whom the liability currently resides must refer the summary report to the actuarial arbiter for decision within 14 days after the party is given the summary report.

115 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by the parties in equal amounts.

116 Payment of amount for total or residual liability

(1) The amount the old insurer must pay the new insurer for the total or residual liability is the amount agreed to by them (the “**agreed amount**”) or, if there is no agreement, the amount decided by the arbiter (the “**decided amount**”).

(2) The old insurer must pay the agreed or decided amount—

- (a) within 3 months after the consent day; or
- (b) on a later day agreed to by the parties.

(3) The agreed or decided amount paid to the new insurer must be adjusted by the actuary of the old insurer to take into account—

- (a) compensation and damages payments made between the assessment day and the day the new insurer assumes liability; and
- (b) claims lodged against the employer or member between the assessment day and the day the new insurer assumes liability.

(4) If WorkCover is neither the old insurer nor the new insurer, the old insurer must advise WorkCover of the following no later than the day total or residual liability is paid—

- (a) the amount of the liability;
- (b) the day the new insurer assumes liability;
- (c) details of the parties and the member leaving or becoming part of the self-insurer.

117 Transfer of claims information

The old insurer must give the new insurer claims information in relation to the liability no later than the day the agreed or decided amount is paid.

Division 3—Liability after cancellation of self-insurer's licence

118 Purpose of div 3

This division sets out the process for the calculation of an amount for a former self-insurer's liability for the Act, section 129.⁴³

119 Appointment of actuary

WorkCover and the former self-insurer must each appoint an actuary to calculate an amount for the liability.

43 The Act, section 129 (Assessing liability after cancellation)

120 Calculation

(1) The calculation must—

- (a) be prepared under the actuarial standard; and
- (b) apply a central estimate of the liability; and
- (c) as far as practicable, be based on the former self-insurer's claims experience; and
- (d) apply the risk free rate of return; and
- (e) include claims administration expenses of 7% of the liability; and
- (f) not include a prudential margin.

(2) The calculation must be based on data as at the last day (the “**assessment day**”) of the financial quarter immediately before the day the former self-insurer's licence is cancelled (the “**cancellation day**”).

121 Former self-insurer to give actuaries information

The former self-insurer must give the actuaries, in the form approved by WorkCover, the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 122(3).

122 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

- (a) be prepared under the actuarial standard; and
- (b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—
 - (i) the average amount of claims for compensation against the former self-insurer; and
 - (ii) the average amount of claims for damages against the former self-insurer; and
 - (iii) claims anticipated to have been incurred by the former self-insurer for which no formal claim has been lodged; and

- (iv) the frequency of claims for compensation against the former self-insurer; and
- (v) the frequency of claims for damages against the former self-insurer; and
- (vi) the net amount of the claims after allowing for future inflation (“**inflated value**”); and
- (vii) the net present value of the inflated value after allowing for income from assets set aside by the former self-insurer to pay the liability; and
- (viii) the rate of inflation used; and
- (c) state the following about the data used in the calculation—
 - (i) the nature of the data;
 - (ii) the actuary’s assessment of its accuracy;
 - (iii) how the actuary interpreted the data; and
- (d) state the actuarial model used in the calculation; and
- (e) state the results of the calculation; and
- (f) state the actuary’s confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports within 35 days after the cancellation day.

123 Summary report

(1) The actuaries must jointly prepare a summary report that—

- (a) includes the individual actuarial reports; and
- (b) states how the individual reports agree or differ.

(2) The actuaries must give the completed summary report to WorkCover and the former self-insurer within 2 months after the cancellation day.

124 Agreement

WorkCover and the former self-insurer may agree on the calculation having regard to the summary report.

125 Reference to actuarial arbiter if no agreement

If WorkCover and the former self-insurer can not agree on the calculation, the former self-insurer must refer the summary report to the actuarial arbiter for decision within 14 days after the former self-insurer is given the summary report.

126 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by WorkCover and the former self-insurer in equal amounts.

127 Payment of amount for liability

(1) The amount the former self-insurer must pay WorkCover for the liability is the amount agreed to by WorkCover and the former self-insurer (the “**agreed amount**”) or, if there is no agreement, the amount decided by the arbiter (the “**decided amount**”).

(2) The agreed or decided amount paid to WorkCover must be adjusted by the former self-insurer's actuary to take into account—

- (a) compensation and damages payments made between the assessment day and the cancellation day; and
- (b) claims lodged against the former self-insurer between the assessment day and the cancellation day.

*Division 4—Actuarial arbiter***128 Function of actuarial arbiter**

The function of the actuarial arbiter is to consider the actuarial reports and the calculations of an amount for liability made under this part and decide on an amount for the liability.

129 Appointment of actuarial arbiter

(1) The actuarial arbiter is to be selected by a selection panel consisting of—

- (a) 2 individuals nominated by WorkCover; and

- (b) 2 individuals nominated by the Queensland Workers' Compensation Self-Insurers' Association.

(2) The individual selected must be a Fellow of the Institute of Actuaries or be an Accredited Member of the Institute.

(3) WorkCover must appoint the individual selected to be the arbiter for a term of not more than 3 years.

(4) The arbiter's conditions of appointment are to be set out in the contract made between WorkCover and the arbiter.

130 Decision of arbiter

(1) After considering the actuarial reports and the calculations of an amount for the liability by the actuaries, the arbiter must decide on—

- (a) the central estimate for the liability; and
(b) an amount for the liability.

(2) An amount for the liability decided by the arbiter can not be more than the higher of the amounts calculated by the actuaries and can not be less than the lower of the amounts.

(3) The arbiter must give a written statement of the arbiter's decision and the reasons for the decision within 21 days after the summary report is referred to the arbiter.

131 Arbiter's decision is final

The arbiter's decision is final.

PART 10—TRANSITIONAL PROVISION

132 Transitional provision for WorkCover Queensland Amendment Regulation (No. 1) 2001

The amendments to this regulation made by the *WorkCover Queensland Amendment Regulation (No. 1) 2001* apply only in relation to an injury resulting to a worker from an event happening after 30 June 2001.

SCHEDULE 1**ADDITIONAL PREMIUM**

section 8

Time of lodgment of declaration of wages	Additional premium
On or after 1 September and not later than 31 October in 1 calendar year	The greater of— (a) 5% of assessed premium for the period of insurance to which the declaration relates; or (b) \$5.00
On or after 1 November and not later than 30 November in 1 calendar year	The greater of— (a) 10% of assessed premium for the period of insurance to which the declaration relates; or (b) \$10.00
On or after 1 December and not later than 31 December in 1 calendar year	The greater of— (a) 15% of assessed premium for the period of insurance to which the declaration relates; or (b) \$15.00
On or after 1 January in the next calendar year	The greater of— (a) 20% of assessed premium for the period of insurance to which the declaration relates, or (b) \$20.00.

SCHEDULE 2

TABLE OF INJURIES

section 55

PART 1—UPPER EXTREMITY INJURIES

Division 1—Preliminary

1 Application of pt 1

(1) This part deals with upper extremity injuries.

(2) The maximum lump sum compensation payable for an upper extremity injury is \$120 000.

(3) To decide a worker's entitlement from injury, division 2 shows—

- (a) the maximum degree of permanent impairment that may result from the injury; and
- (b) the maximum lump sum compensation payable for the injury; and
- (c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists certain upper extremity injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the upper extremity.

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

SCHEDULE 2 (continued)

(5) These injuries may result in the same degree of maximum permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 55 and 56 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from an injury to an upper extremity is expressed in division 2 as a degree of permanent impairment of the upper extremity.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If an injury to an upper extremity results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in an injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the upper extremity.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the upper extremity for this part.

(8) For section 55 of the regulation, the relevant provision of the AMA guide is chapter 3.

SCHEDULE 2 (continued)

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple injuries to the upper extremity—

$$\frac{\text{DPI} \times \text{MLSC}}{100}$$

(2) However, for a single injury (other than an injury involving sensory loss) to the index, ring or little finger, the following formula must be used—

$$\frac{\text{DPI} \times \text{LSC}}{\text{MDPI}}$$

(3) Also, for multiple injuries where at least 1 injury (other than sensory loss) is to the index, ring or little finger, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1) and (2).

(4) In this section—

“**DPI**” means the degree of permanent impairment of the upper extremity assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

“**LSC**” means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

“**MDPI**” means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

“**MLSC**” means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 2 (continued)

Division 2—Upper extremity injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
1100	Fingers and hand			
1101	Loss of thumb	36	43 200	28.8
1102	Loss of joint of thumb . .	18	21 600	14.4
1103	Sensory loss to palmar surface of thumb	18	21 600	14.4
1104	Sensory loss on either side of thumb.	8	9 600	6.4
1105	*Loss of index finger . .	18	24 435	16.29
1106	*Loss of 2 joints of index finger	13	18 330	12.22
1107	*Loss of distal joint to index finger	8	12 210	8.14
1108	Sensory loss to palmar surface of index finger . .	8	9 600	6.4
1109	Sensory loss on either side of index finger	5	6 000	4
1110	Loss of middle finger . .	18	21 600	14.4
1111	Loss of 2 joints of middle finger	13	15 600	10.4
1112	Loss of distal joint of middle finger	8	9 600	6.4
1113	Sensory loss to palmar surface of middle finger	8	9 600	6.4
1114	Sensory loss on either side of middle finger . . .	5	6 000	4
1115	*Loss of ring finger . . .	8	12 210	8.14
1116	*Loss of 2 joints of ring finger	6	12 210	8.14

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
1117	*Loss of distal joint of ring finger	5	7 335	4.89
1118	Sensory loss on either side of ring finger	3	3 600	2.4
1119	Sensory loss to palmar surface of ring finger . . .	5	6 000	4
1120	Sensory loss on either side of ring finger	3	3 600	2.4
1121	*Loss of little finger . . .	8	12 210	8.14
1122	*Loss of 2 joints of little finger	6	12 210	8.14
1123	*Loss of distal joint of little finger	5	7 335	4.89
1124	Sensory loss to palmar surface of little finger . .	5	6 000	4
1125	Sensory loss on either side of little finger	3	3 600	2.4
1126	Loss of hand or arm below the elbow	90	108 000	72
1127	Aggravation of Dupuytren's contracture	0	0	0
1128	Crush injury to hand with multiple fractures (healed with no deformities) but resulting in mild loss of motion of all fingers with extensive scarring and soft tissue damage .	40	48 000	32

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
1200	Wrist			
1201	De Quervains disease, whether operated or non-operated	0	0	0
1202	Ganglion, whether operated or non-operated, with or without residual subjective symptoms or signs e.g. swelling or tenderness	0	0	0
1203	Carpal tunnel syndrome, non-operated, with no residual subjective symptoms or signs.	0	0	0
1204	Carpal tunnel syndrome, whether operated or non-operated, with residual subjective symptoms or signs e.g. dysaesthesia or muscle wasting	2	2 400	1.6
1205	Fractured scaphoid, non-operated and healed with no residual subjective symptoms or signs	0	0	0
1206	Fractured scaphoid, operated.	5	6 000	4
1207	Fractured scaphoid, worst possible outcome i.e. fusion of the wrist joint.	60	72 000	48

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
1208	Fracture of radius or ulna or carpus bones with moderate limitation of wrist movements and mild limitation of elbow movements	16	19 200	12.8
1300	Elbow			
1301	Medial or lateral epicondylitis of elbow, non-operated with no residual subjective symptoms or signs.	0	0	0
1302	Medial or lateral epicondylitis of elbow, whether operated or non-operated, with residual subjective symptoms or signs e.g. pain and tenderness.	2	2 400	1.6
1303	Injury to elbow region resulting in moderate loss of all movements	31	37 200	24.8
1400	Shoulder and arm			
1401	Injury to shoulder region resulting in mild loss of all movements	6	7 200	4.8
1402	Injury to shoulder region resulting in moderate loss of all movements	16	19 200	12.8

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
1403	Total loss of function of shoulder joint	60	72 000	48
1404	Loss of an arm.	100	120 000	80

PART 2—LOWER EXTREMITY INJURIES*Division 1—Preliminary***1 Application of pt 2**

(1) This part deals with lower extremity injuries.

(2) The maximum lump sum compensation payable for a lower extremity injury is \$112 500.

(3) To decide a worker's entitlement from injury, division 2 shows—

- (a) the maximum degree of permanent impairment that may result from the injury; and
- (b) the maximum lump sum compensation payable for the injury; and
- (c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists certain lower extremity injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

SCHEDULE 2 (continued)

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the lower extremity.

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

(5) These injuries may result in the same degree of maximum permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 55 and 56 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from an injury to a lower extremity is expressed in division 2 as a degree of permanent impairment of the lower extremity.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If an injury to a lower extremity results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in an injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the lower extremity.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the lower extremity for this part.

SCHEDULE 2 (continued)

(8) For section 55 of the regulation, the relevant provision of the AMA guide is chapter 3.

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple injuries to the lower extremity—

$$\frac{\text{DPI} \times \text{MLSC}}{100}$$

(2) However, for a single injury to a toe, the following formula must be used—

$$\frac{\text{DPI} \times \text{LSC}}{\text{MDPI}}$$

(3) Also, for multiple injuries where at least 1 injury (but not all injuries) is to the toes, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1) and (2).

(4) Also, for multiple toe injuries, the formula in subsection (2) must be used, but the value of LSC is as specified in division 2.

(5) In this section—

“**DPI**” means the degree of permanent impairment of the lower extremity assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

“**LSC**” means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

“**MDPI**” means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

“**MLSC**” means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 2 (continued)

Division 2—Lower extremity injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
2100	Toes and foot			
2101	*Loss of any toe (other than great toe)	2	12 210	8.14
2102	*Loss of great toe	12	24 435	16.29
2103	*Loss of joint of great toe	5	12 210	8.14
2104	Fracture of any metatarsal, worst possible outcome e.g. pain or loss of weight transfer	10	11 250	7.5
2105	Mid-foot amputation . . .	45	50 625	33.75
2106	Loss of a foot	63	70 875	47.25
2107	*Loss of two toes (other than great toe) of a foot.	4	15 000	10
2108	*Loss of three toes (other than great toe) of a foot	6	17 625	11.75
2109	*Loss of four toes (other than great toe) of a foot.	8	20 250	13.5
2110	*Loss of great toe and one other toe of a foot . .	14	30 000	20
2111	*Loss of great toe and two other toes of a foot .	16	37 500	25
2112	*Loss of great toe and three other toes of a foot	18	45 000	30
2113	*Loss of joint of great toe and one other toe of a foot	7	15 000	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
2114	*Loss of joint of great toe and two other toes of a foot	9	17 625	11.75
2115	*Loss of joint of great toe and three other toes of a foot	11	20 250	13.5
2116	*Loss of joint of great toe and four other toes of a foot	13	22 875	15.25
2117	*Loss of all toes of a foot	20	50 625	33.75
2200	Ankle			
2201	Ankylosis of ankle in neutral position	10	11 250	7.5
2202	Unstable ankle with ligamentous insufficiency, whether operated or non-operated	15	16 875	11.25
2203	Total loss of function of ankle joint with ankylosis in unfavourable position, worst possible outcome.	62	69 750	46.5
2204	Fracture of os calcis, worst possible outcome.	25	28 125	18.75

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
2205	Fracture of tibia and fibula resulting in shortening of the leg, gait difficulty, muscle wasting in the calf and moderate permanent stiffness of the knee and ankle joints	50	56 250	37.5
2300	Knee			
2301	Chondromalacia patellae, non-operated . .	0	0	0
2302	Chondromalacia patellae, operated	2	2 250	1.5
2303	Patellar subluxation or dislocation with residual instability.	7	7 875	5.25
2304	Patellar fracture, whether operated or non-operated	12	13 500	9
2305	Patellectomy	22	24 750	16.5
2306	Single meniscectomy . .	7	7 875	5.25
2307	Mild aggravation of pre-existing degenerative disease in knee with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
2308	Moderate to severe aggravation or acceleration of pre-existing disease in knee with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	7	7 875	5.25
2309	Injury to knee region resulting in moderate loss of all movements . .	20	22 500	15
2310	Unstable knee (cruciate or collateral ligament insufficiency), whether operated or non-operated	25	28 125	18.75
2311	Unstable knee (cruciate and collateral ligament insufficiency), whether operated or non-operated	37	41 625	27.75
2312	Total knee replacement .	50	56 250	37.5
2313	Below knee amputation.	80	90 000	60
2314	Above knee amputation	100	112 500	75

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
2400	Hip joint and leg			
2401	Mild aggravation of pre-existing degenerative disease in hip joint with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
2402	Moderate to severe aggravation or acceleration of pre-existing disease in hip joint with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	7	7 875	5.25
2403	Injury to hip region resulting in mild loss of all movements	12	13 500	9
2404	Injury to hip region resulting in moderate loss of all movements . .	25	28 125	18.75
2405	Healed fracture of femur with moderate angulation or deformity.	45	50 625	33.75
2406	Fracture of femoral neck	50	56 250	37.5
2407	Total hip replacement . .	45	50 625	33.75
2408	Loss of a leg	100	112 500	75

SCHEDULE 2 (continued)

PART 3—SPECIAL PROVISION INJURIES*Division 1—Preliminary***1 Application of pt 3**

(1) This part deals with vision and hearing injuries and injury involving loss of a breast.

(2) The maximum lump sum compensation payable for a vision injury under this part is \$150 000.

(3) The maximum lump sum compensation payable for a hearing injury under this part is \$61 095.

(4) The maximum lump sum compensation payable for loss of a breast under this part is \$45 000.

2 How to use this part of the table

(1) Division 2 lists certain vision and hearing injuries and injury involving loss of a breast.

(2) Vision and hearing injuries and injury involving loss of a breast are stated in column 2, the maximum lump sum compensation for the injury is stated in column 3, and the maximum WRI is stated in column 4.

(3) Some injuries mentioned in division 2 are marked with an asterisk (*).

(4) For historical reasons, the maximum lump sum compensation payable for these injuries may be higher relative to other injuries mentioned in this division.

(5) For more information on how to use the table of injuries, see section 55 of the regulation.

3 Interaction between this part and the assessment guides

(1) The lump sum compensation payable for a vision or hearing injury mentioned in division 2 is the maximum lump sum compensation payable for the injury.

SCHEDULE 2 (continued)

(2) If a vision or hearing injury results in permanent impairment of vision or hearing and the injury is not mentioned in division 2, the degree of permanent impairment resulting from the injury must be assessed under the relevant assessment guide.

(3) The degree of permanent impairment must be expressed as a degree of total vision or hearing loss—

- (a) for each eye or ear; or
- (b) if the injury is to both eyes or both ears—of both eyes or both ears.

(4) In this section—

“**relevant assessment guide**” means—

- (a) for a vision injury—the ophthalmologists guide; or
- (b) for a hearing injury—the hearing loss tables.

4 Formula to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for a vision or hearing injury—

$$\frac{\text{DPI} \times \text{LSC}}{100}$$

(2) However, for multiple injuries involving at least 1 of an injury to vision, hearing or a breast, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1).

(3) In this section—

“**DPI**” means—

- (a) for hearing loss from industrial deafness—the assessed degree of permanent impairment resulting from the injury less 5%;⁴⁴ and
- (b) for another injury under this part—the assessed degree of permanent impairment resulting from the injury.

⁴⁴ For more information about the 5% reduction, see section 152 (Entitlements for industrial deafness) of the Act.

SCHEDULE 2 (continued)

“LSC” means the lump sum compensation payable under this part for the injury.

Division 2—Special provision injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum lump sum compensation \$	Column 4 Maximum WRI %
3100	Vision		
3101	*Loss of vision in 1 eye (corrected vision)	48 870	32.58
3102	*Total loss of vision in 1 eye resulting from loss of an eyeball.	54 975	36.65
3103	Total loss of vision	150 000	100
3104	Total loss of vision of 1 eye with serious diminution of vision in the other eye (less than 10% vision remaining) . .	127 500	85
3200	Hearing		
3201	Loss of hearing in 1 ear.	30 000	20
3202	*Binaural hearing loss.	61 095	40.73
3300	Injury to breast		
3301	*Loss of breast	45 000	30

SCHEDULE 2 (continued)

PART 4—OTHER INJURIES*Division 1—Preliminary***1 Application of pt 4**

(1) This part deals with the following injuries (“**system injuries**”)—

- (a) injuries to the musculo-skeletal system;
- (b) injuries to the nervous system;
- (c) injuries to the respiratory system;
- (d) injuries to the cardiovascular system;
- (e) injuries to the alimentary system;
- (f) injuries to the urinary or reproductive system;
- (g) injuries to the skin.

(2) The maximum lump sum compensation payable for an injury under this part is \$150 000.

(3) To decide a workers entitlement from injury, division 2 shows—

- (a) the maximum degree of permanent impairment that may result from the injury; and
- (b) the maximum lump sum compensation payable for the injury; and
- (c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists certain system injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the whole person.

SCHEDULE 2 (continued)

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

(5) These injuries may result in the same degree of permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 55 and 56 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from a system injury is expressed in division 2 as a degree of permanent impairment of the whole person.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If a system injury results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in a system injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the whole person.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the whole person for this part.

(8) For section 55 of the regulation, the relevant provisions of the AMA guide are—

- (a) for injuries to the cervicothoracic, thoracolumbar or lumbosacral spine—chapter 3; and

SCHEDULE 2 (continued)

- (b) for injuries to the pelvis—chapter 3; and
- (c) for injuries to the brain and cranial nerves—chapters 4 and 9; and
- (d) for spinal cord injuries—chapters 3 and 4; and
- (e) for respiratory system injuries—chapter 5; and
- (f) for cardiovascular system injuries—chapter 6; and
- (g) for alimentary system injuries—chapter 10; and
- (h) for urinary or reproductive system injuries—chapter 11; and
- (i) for skin injuries—chapter 13.

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple system injuries—

$$\frac{\text{DPI} \times \text{MLSC}}{100}$$

(2) However, for loss of smell, taste or speech, a cervical cord injury (with or without fracture) or complete paraplegia, the following formula must be used—

$$\frac{\text{DPI} \times \text{LSC}}{\text{MDPI}}$$

(3) Also, for multiple injuries involving at least 1 injury that is loss of smell, taste or speech, a cervical cord injury or paraplegia, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsections (1) and (2).

(4) In this section—

“**DPI**” means the degree of permanent impairment of the whole person assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

“**LSC**” means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

SCHEDULE 2 (continued)

“**MDPI**” means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

“**MLSC**” means the maximum lump sum compensation specified in section 1(2).

Division 2—System injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4100	Musculo-skeletal system			
	Cervicothoracic spine			
4101	Hyperextension musculo-ligamentous injury to cervical spine region with subjective symptoms, but no significant clinical findings	0	0	0
4102	Mild aggravation of pre-existing degenerative disease in cervical spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4103	Moderate to severe aggravation or acceleration of pre-existing degenerative disease in cervical spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 500	5
4104	Compression fracture of a vertebral body(s) or posterior element fracture (spinous or transverse process) without dislocation, healed with no complications, but local subjective symptoms, referred pain and mild restriction of neck movements	5	7 500	5
4105	Prolapsed intervertebral disc in cervical spine with referred pain, non-operated with resolution of subjective symptoms, and no loss of range of movements .	10	15 000	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4106	Prolapsed intervertebral disc in cervical spine with referred pain, treated surgically by discectomy and fusion with resolution of referred pain. Persisting neck pain with moderate loss of range of movements	15	22 500	15
4107	Vertebral fractures or dislocations of cervical spine, treated surgically by fusion with no residual neurological compromise, but severe loss of range of movements	25	37 500	25
Thoracolumbar spine				
4108	Mild aggravation of pre-existing degenerative disease in thoracic spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4109	Moderate to severe aggravation or acceleration of pre-existing degenerative disease in thoracic spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 500	5
4110	Minor compression fracture of vertebral body(s) in thoracic spine, healed with subjective symptoms, but no physical signs . . .	5	7 500	5
4111	Major compression fracture of vertebral body(s) in thoracic spine, healed with subjective symptoms, but no physical signs . . .	10	15 000	10
Lumbosacral spine				
4112	Musculo-ligamentous injury to lumbosacral spine region with subjective symptoms, but no significant clinical findings	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4113	Mild aggravation of pre-existing degenerative disease in lumbosacral spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
4114	Moderate to severe aggravation or acceleration of pre-existing disease in lumbosacral spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 500	5
4115	Moderate to severe aggravation of pre-existing spondylolisthesis, treated surgically by discectomy or fusion with resolution of symptoms	10	15 000	10
4116	Minor compression fracture of vertebral body(s) in lumbar region, healed with subjective symptoms, but no physical signs . . .	5	7 500	5

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4117	Major compression fracture of vertebral body(s) in lumbar region, healed with subjective symptoms, but no physical signs . . .	10	15 000	10
4118	Prolapsed intervertebral disc in lumbosacral spine with referred pain, non-operated with resolution of referred pain and back pain. No loss of range of movements	10	15 000	10
4119	Prolapsed intervertebral disc in lumbosacral spine with referred pain, treated surgically by discectomy or fusion with resolution of referred pain, but persisting low back pain. Mild loss of range of movements	15	22 500	15
4120	Prolapsed intervertebral disc in lumbosacral spine with referred pain, treated surgically by discectomy or fusion, but with persisting referred pain and low back pain. Moderate loss of range of movements .	25	37 500	25

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
Pelvis				
4121	Healed fracture of pelvis without displacement in any region (other than acetabulum, coccyx and sacrum) with subjective symptoms, but no significant signs.	0	0	0
4122	Healed fracture of pelvis with displacement in any region (other than acetabulum, coccyx and sacrum) with subjective symptoms, but no significant signs.	5	7 500	5
4123	Fracture of coccyx, whether operated or non-operated.	5	7 500	5
4124	Healed fracture(s) of pelvis in any region (other than acetabulum, coccyx and sacrum) with displacement and deformity and subjective symptoms and signs . . .	10	15 000	10
4125	Fracture of sacrum with or without involvement of the sacro-iliac joint with subjective symptoms and signs . . .	10	15 000	10
4126	Fracture or dislocation of symphysis or sacro-iliac joint.	10	15 000	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4127	Fracture of acetabulum with displacement and deformity and residual subjective symptoms and signs in hip joint . . .	50	75 000	50
4200	Nervous system			
	Brain and cranial nerves			
4201	Mild vertigo with subjective symptoms, but no significant signs .	0	0	0
4202	Severe vertigo with subjective symptoms and signs and totally dependent	70	105 000	70
4203	*Loss of smell	3	18 330	12.22
4204	*Loss of smell and taste	6	30 540	20.36
4205	*Loss of speech	35	85 530	57.02
4206	Fracture of the mid third of the face with permanent nerve involvement	24	36 000	24
4207	Chronic organic brain syndrome i.e. diffuse brain damage following head injuries, cerebral anoxia, inhalation of toxic substances etc., worst possible outcome.	100	150 000	100
	Spinal cord injuries			
4208	*Cervical cord injury with or without fracture	75	135 000	90

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4209	Thoracic cord injury with or without fracture	60	90 000	60
4210	Cauda equina syndrome with or without fracture	60	90 000	60
4211	*Complete paraplegia . .	75	135 000	90
4212	Totally dependent quadriplegia.	100	150 000	100
4300	Respiratory system			
4301	Healed fractured rib(s) with subjective symptoms, but no significant signs.	0	0	0
4302	Healed pulmonary contusion with subjective symptoms, but no significant signs .	0	0	0
4303	Toxic inhalation injury, hypersensitivity pneumonitis, pneumoconioses, occupational asthma, C.O.A.D. (bronchitis or emphysema), R.A.D.S. (Reactive airways dysfunction syndrome), pulmonary embolus, all on optimal medical management—			
	• no respiratory subjective symptoms or significant signs. . .	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
	<ul style="list-style-type: none"> • mild respiratory subjective symptoms or minor signs • moderate respiratory subjective symptoms or moderate signs . . . • severe respiratory subjective symptoms or significant signs . . . 	25	37 500	25
4304	Mesothelioma or lung cancer	100	150 000	100
		100	150 000	100
4400	Cardiovascular system			
	Coronary artery disease			
4401	A history of angina with demonstrated constitutional coronary artery disease, on optimal medical treatment	0	0	0
4402	A history of myocardial infarction, with no post infarction angina, on optimal medical treatment	15	22 500	15
4403	A history of myocardial infarction with persisting post infarction angina, on optimal medical treatment	50	75 000	50

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4404	A history of myocardial infarction with persisting post infarction angina and subjective symptoms and signs of congestive heart failure, on optimal medical treatment	100	150 000	100
4500	Alimentary system			
4501	Musculo-ligamentous injury to abdominal wall	0	0	0
4502	Splenectomy	5	7 500	5
4503	Subjective symptoms (e.g. local pain or dysaesthesia) following hernia repair(s), but no significant signs.	0	0	0
4504	Subjective symptoms and signs (e.g. pain or dysaesthesia, tenderness) following hernia repair(s)	2	3 000	2
4505	Primary or recurrent hernia when surgery is an absolute contraindication.	10	15 000	10
4506	Viral hepatitis—			
	• mild	25	37 500	25
	• moderate	50	75 000	50
	• severe	100	150 000	100

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4600	Urinary and reproductive systems			
4601	Loss of 1 kidney	10	15 000	10
4602	Urinary incontinence. . .	60	90 000	60
4603	Loss of both kidneys or only functioning kidney	100	150 000	100
4604	Loss of fertility	15	22 500	15
4605	Impotence	15	22 500	15
4606	Loss of sexual function (both impotence and infertility)	30	45 000	30
4607	Loss of genital organs . .	50	75 000	50
4700	Skin			
4701	Contact irritant dermatitis. Removal from exposure to irritant results in resolution of signs and subjective symptoms with no ongoing treatment required.	0	0	0
4702	Aggravation of constitutional dermatitis, resolved by removal from exposure to irritant	0	0	0
4703	Moderate solar induced skin disease that is non-malignant.	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
4704	Chronic contact dermatitis. Signs and subjective symptoms persist intermittently on removal from exposure to the primary irritant. Intermittent treatment required.....	10	15 000	10
4705	Chronic contact dermatitis. Signs and subjective symptoms persist almost continuously on removal from exposure to the primary irritant. Intermittent to constant treatment required.....	20	30 000	20
4706	Solar induced skin disease that is malignant	25	37 500	25
4707	Persistent neurodermatitis secondary to occupational contact irritant dermatitis. Signs and subjective symptoms persist continuously on removal from exposure to the primary irritant and are exacerbated by exposure to secondary irritants. Constant treatment required.....	30	45 000	30

SCHEDULE 2 (continued)

PART 5—PRESCRIBED DISFIGUREMENT*Division 1—Preliminary***1 Application of pt 5**

(1) This part deals with prescribed disfigurement.

(2) The maximum lump sum compensation payable for prescribed disfigurement is \$75 000.

(3) To decide a workers entitlement from injury, division 2 shows—

- (a) the maximum degree of permanent impairment that may result from the injury; and
- (b) the maximum lump sum compensation payable for the injury; and
- (c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists prescribed disfigurements.

(2) Prescribed disfigurements resulting from injury are stated in column 2, the maximum percentage of permanent impairment resulting from the disfigurement is stated in column 3,⁴⁵ the maximum lump sum compensation for the disfigurement is stated in column 4, and the maximum WRI is stated in column 5.

⁴⁵ The actual percentage of permanent impairment resulting from the prescribed disfigurement must be assessed having regard to the severity of the prescribed disfigurement—see section 155(3) (Entitlements of worker who sustains prescribed disfigurement) of the Act.

SCHEDULE 2 (continued)

Division 2—Prescribed disfigurement

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
5100	Prescribed disfigurement			
5101	Mild almost invisible linear scarring following surgery or trauma in lines of election to any part(s) of the body with minimal discolouration, normal texture and elevation	0	0	0
5102	Moderate linear scarring following surgery or trauma crossing lines of election to any part(s) of the body with minimal discolouration, normal texture and elevation . . .	2	1 500	1
5103	Moderate to severe linear scarring following surgery or trauma in or crossing lines of election to any part(s) of the body. Discoloured, indurated, atrophic or hypertrophic	10	7 500	5
5104	Area scarring to any part(s) of the body following surgery or trauma. Atrophic or hypertrophic, markedly discoloured	20	15 000	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation \$	Column 5 Maximum WRI %
5105	Depressed cheek, nasal or frontal bones following trauma	35	26 250	17.5
5106	Loss, or severe deformity, of outer ear . .	40	30 000	20
5107	Severe, bilateral gross facial deformity following burns or other trauma	50	37 500	25
5108	Loss of entire nose	50	37 500	25
5109	Gross scarring following burns to multiple body areas. Some areas healing spontaneously and some requiring grafting. Gross scarring at the burn and donor sites. Outcome resulting in fragile, dry, cracking skin at graft sites necessitating the need for wearing of special garments. Severe cases resulting in loss of sweat glands and lack of sweating leading to the necessity to be in a continuous air conditioned environment	100	75 000	50

SCHEDULE 2 (continued)

PART 6—PSYCHIATRIC OR PSYCHOLOGICAL INJURIES**1 Application of pt 6**

(1) This part deals with psychiatric or psychological injuries.

(2) The maximum lump sum compensation payable for a psychiatric or psychological injury is \$150 000.

(3) However, most injuries will entitle an injured worker to a lesser amount.

2 Interaction between this part and the AMA guide

(1) Permanent impairment resulting from a psychiatric or psychological injury must be assessed under the AMA guide.

(2) Permanent impairment resulting from an injury must be expressed as a degree of permanent impairment of the whole person.

(3) The degree of permanent impairment so expressed is taken to be the maximum degree of permanent impairment for this part.

(4) For section 55 of the regulation, the relevant provision of the AMA guide is chapter 14.

3 Formula to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for psychiatric or psychological injuries—

$$\frac{\text{DPI} \times \text{MLSC}}{100}$$

(2) In this section—

“**DPI**” means the degree of permanent impairment assessed by a registered person as resulting from the injury.

“**MLSC**” means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 3**GRADUATED SCALE OF ADDITIONAL
COMPENSATION FOR CERTAIN WORKERS**

section 59

1 Graduated scale

(1) This schedule contains the graduated scale for additional compensation for a worker who sustains an injury that results in a WRI of 50% or more.

(2) The maximum amount of lump sum compensation payable under this schedule is \$150 000.

2 How to use the graduated scale

(1) The WRI calculated under section 201⁴⁶ of the Act is shown in column 2.

(2) A worker who sustains a WRI shown in column 2 is entitled to additional lump sum compensation in the amount shown for the corresponding entry in column 3.

GRADUATED SCALE

Column 1 Code No.	Column 2 WRI %	Column 3 Additional lump sum compensation \$
8100	50	5 790
8101	51	11 550
8102	52	17 325

46 Section 201 (Calculation of WRI) of the Act

SCHEDULE 3 (continued)

8103	53	23 085
8104	54	28 860
8105	55	34 620
8106	56	40 395
8107	57	46 170
8108	58	51 930
8109	59	57 705
8110	60	63 465
8111	61	69 240
8112	62	75 000
8113	63	80 790
8114	64	86 550
8115	65	92 325
8116	66	98 085
8117	67	103 860
8118	68	109 620
8119	69	115 395
8120	70	121 170
8121	71	126 930
8122	72	132 705
8123	73	138 465
8124	74	144 240
8125	75–100	150 000

SCHEDULE 4

GRADUATED SCALE FOR ADDITIONAL COMPENSATION FOR GRATUITOUS CARE

section 60

1 Graduated scale

(1) This schedule contains the graduated scale for additional compensation for gratuitous care.

(2) The maximum amount of lump sum compensation payable under this schedule is \$150 000.

2 How to use this graduated scale

(1) The WRI calculated under section 201⁴⁷ of the Act is shown in column 2.

(2) The range of dependency assessed under the modified barthel index is shown in column 3.

(3) In column 3—

- moderate is a modified barthel index total score of 50-74
- severe is a modified barthel index total score of 25-49
- total is a modified barthel index total score of 0-24.

(4) The worker's additional lump sum compensation entitlement is shown for the corresponding entry in column 4.

47 Section 201 (Calculation of WRI) of the Act

SCHEDULE 4 (continued)

GRADUATED SCALE

Column 1 Code number	Column 2 WRI %	Column 3 Range of dependency (modified barthel index)	Column 4 Additional lump sum compensation \$
9100 9101 9102	50–59	Moderate Severe Total	10 000 20 000 30 000
9103 9104 9105	60–69	Moderate Severe Total	25 000 45 000 60 000
9106 9107 9108	70–79	Moderate Severe Total	35 000 65 000 90 000
9109 9110 9111	80–89	Moderate Severe Total	40 000 80 000 120 000
9112 9113 9114	90–94	Moderate Severe Total	45 000 90 000 140 000
9115 9116 9117	95–100	Moderate Severe Total	50 000 100 000 150 000
9094 9095 9096	15–39	Moderate Severe Total	1 500 3 000 4 500
9097 9098 9099	40–49	Moderate Severe Total	2 800 5 700 8 500

SCHEDULE 5

GRADUATED SCALE OF CARE REQUIRED FOR PAYMENT OF CARING ALLOWANCE

section 62

1 Graduated scale

This schedule contains the graduated scale for the payment of caring allowance.

2 How to use this graduated scale

(1) The range of dependency assessed under the modified barthel index is shown in column 1.

(2) In column 1—

- minimal is a modified barthel index total score of 91-99
- mild is a modified barthel index total score of 75-90
- moderate is a modified barthel index total score of 50-74
- severe is a modified barthel index total score of 25-49
- total is a modified barthel index total score of 0-24.

(3) The maximum number of hours of care required in a week is shown for the corresponding entry in column 2.

SCHEDULE 5 (continued)

GRADUATED SCALE

Column 1 Range of dependency (modified barthel index)	Column 2 Maximum hours of care required in a week
Minimal	<10
Mild	13.0
Moderate	20.0
Severe	23.5
Total	27.0

SCHEDULE 6**LEGAL PROFESSIONAL COSTS**

section 78

Column A Pre-proceeding notification and negotiation	Column B Compulsory conference	Column C Investigation by expert	Column D Pre-proceedings court applications
\$2 000	\$135 for the first hour or part of an hour \$105 for each additional hour or part of an hour	\$270	\$400

ENDNOTES**1 Index to endnotes**

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2 Date to which amendments incorporated

This is the reprint date mentioned in the Reprints Act 1992, section 5(c). Accordingly, this reprint includes all amendments that commenced operation on or before 9 November 2001. Future amendments of the WorkCover Queensland Regulation 1997 may be made in accordance with this reprint under the Reprints Act 1992, section 49.

3 Key**Key to abbreviations in list of legislation and annotations**

Key	Explanation	Key	Explanation
AIA	= Acts Interpretation Act 1954	prev	= previous
amd	= amended	(prev)	= previously
amdt	= amendment	proc	= proclamation
ch	= chapter	prov	= provision
def	= definition	pt	= part
div	= division	pubd	= published
exp	= expires/expired	R[X]	= Reprint No.[X]
gaz	= gazette	RA	= Reprints Act 1992
hdg	= heading	reloc	= relocated
ins	= inserted	renum	= renumbered
lap	= lapsed	rep	= repealed
notfd	= notified	s	= section
o in c	= order in council	sch	= schedule
om	= omitted	sdiv	= subdivision
orig	= original	SIA	= Statutory Instruments Act 1992
p	= page	SIR	= Statutory Instruments Regulation 1992
para	= paragraph	SL	= subordinate legislation
prec	= preceding	sub	= substituted
pres	= present	unnum	= unnumbered

4 Table of earlier reprints

TABLE OF EARLIER REPRINTS

[If a reprint number includes a roman letter, the reprint was released in unauthorised, electronic form only.]

Reprint No.	Amendments included	Reprint date
1	to SL No. 161 of 1997	1 July 1997
2	to SL No. 153 of 1999	2 July 1999
2A	to SL No. 143 of 2000	7 July 2000
2B	to SL No. 312 of 2000	15 December 2000

5 List of legislation

WorkCover Queensland Regulation 1997 SL No. 17

made by the Governor in Council on 30 January 1997
 notfd gaz 31 January 1997 pp 376–8
 ss 1–2 commenced on date of notification
 remaining provisions commenced 1 February 1997 (see s 2)
exp 1 September 2007 (see SIA s 54)
 Note— An explanatory note only was prepared
 as amended by—

WorkCover Queensland Amendment Regulation (No. 1) 1997 SL No. 161

notfd gaz 20 June 1997 pp 879–82
 ss 1–2 commenced on date of notification
 remaining provisions commenced on 1 July 1997
 Note— An explanatory note only was prepared

WorkCover Queensland Amendment Regulation (No. 1) 1999 SL No. 153

notfd gaz 2 July 1999 pp 1223–4
 s 11 (so far as it inserts new pt 8) commenced 1 July 1999 (see s 2(1))
 sch commenced 1 July 2000 (see s 2(2))
 remaining provisions commenced on date of notification

Employment, Training and Industrial Relations Legislation Amendment Regulation

(No. 1) 2000 SL No. 143 pts 1, 4

notfd gaz 30 June 2000 pp 736–48
 ss 1–2 commenced on date of notification
 remaining provisions commenced 1 July 2000 (see s 2)

WorkCover Queensland Amendment Regulation (No. 1) 2000 SL No. 312

notfd gaz 8 December 2000 pp 1374–7
 ss 4–7 commenced 1 July 2001 (see s 2)
 remaining provisions commenced on date of notification

WorkCover Queensland Amendment Regulation (No. 1) 2001 SL No. 197

notfd gaz 25 October 2001 pp 645A–645B

ss 1–2, 6 commenced on date of notification

remaining provisions commenced 1 July 2001 (see s 2)

6 List of annotations**This reprint has been renumbered—see table of renumbered provisions in endnote 7.****Definitions**

- s 3** def “**actuarial standard**” ins 1999 SL No. 153 s 4
 def “**actuary**” ins 1999 SL No. 153 s 4
 def “**arbiter**” ins 1999 SL No. 153 s 4
 def “**assessed premium**” ins 1997 SL No. 161 s 4
 amd 1999 SL No. 153 s 3 sch
 def “**central estimate**” ins 1999 SL No. 153 s 4
 def “**claim**” ins 1999 SL No. 153 s 4
 def “**excess period**” ins 1997 SL No. 161 s 4
 def “**financial quarter**” ins 1999 SL No. 153 s 4
 def “**further premium**” ins 1997 SL No. 161 s 4
 amd 2000 SL No. 312 s 4
 def “**premium**” ins 1997 SL No. 161 s 4(2)
 def “**premium**” om 2000 SL No. 312 s 4(1)
 def “**provisional premium**” ins 1997 SL No. 161 s 4
 amd 1999 SL No. 153 s 3 sch
 def “**prudential margin**” ins 1999 SL No. 153 s 4
 def “**risk free of return**” ins 1999 SL No. 153 s 4

Scheme solvency—Act, s 5

- s 4** ins 1997 SL No. 161 s 5
 amd 1999 SL No. 153 s 5

PART 2—EMPLOYER INSURANCE

- pt hdg** sub 1997 SL No. 161 s 6

Division 1—Policies and premium assessments

- div hdg** ins 1997 SL No. 161 s 6

Application for policy

- s 5** sub 1997 SL No. 161 s 6

Policies and renewals

- s 6** ins 1997 SL No. 161 s 6

Assessment of premium

- s 7** ins 1997 SL No. 161 s 6
 amd 1999 SL No. 153 s 3 sch; 2000 SL No. 143 s 10

Declaration of wages

- s 8** ins 1997 SL No. 161 s 6
 amd 1999 SL No. 153 s 3 sch

Value of board and lodging

s 9 ins 1997 SL No. 161 s 6

Payment of premium by instalments

s 10 ins 1997 SL No. 161 s 6

Additional premium for late payment—Act, ss 65 and 66

s 11 ins 1997 SL No. 161 s 6

Deemed premium—s 31s 12 ins 1997 SL No. 161 s 6
sub 2000 SL No. 312 s 5**Deemed premium—Act, s 515(2)(a)**s 13 ins 1997 SL No. 161 s 6
amd 1999 SL No. 153 s 6
sub 2000 SL No. 312 s 5**Cancellation of policy on ceasing to employ workers**s 14 ins 1997 SL No. 161 s 6
amd 1999 SL No. 153 s 3 sch**Documents to be kept—Act, s 469**

s 15 ins 1997 SL No. 161 s 6

Division 2—Employer excess

div hdg ins 1997 SL No. 161 s 6

Excess period—Act, s 69

s 16 ins 1997 SL No. 161 s 6

Employer's election to insure against payment for excess period—Act, s 71

s 17 ins 1997 SL No. 161 s 6

Amount payable to insure against payment for excess period—Act, s 71

s 18 ins 1997 SL No. 161 s 6

Division 3—Self-ratingdiv hdg ins 1997 SL No. 161 s 6
om 1999 SL No. 153 s 3 sch**Definition for div 3**s 19 ins 1997 SL No. 161 s 6
om 1999 SL No. 153 s 3 sch**Premium calculation—Act, s 74**s 20 ins 1997 SL No. 161 s 6
om 1999 SL No. 153 s 3 sch**Provisional premium**s 21 ins 1997 SL No. 161 s 6
om 1999 SL No. 153 s 3 sch**Assessed premium**s 22 ins 1997 SL No. 161 s 6
om 1999 SL No. 153 s 3 sch

Adjustment for liability for prior periods of insurance

- s 23 ins 1997 SL No. 161 s 6
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