



# Application for Loss of Earnings Allowance

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

### Loss of earnings allowance

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

The amount paid is:

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

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

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

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

### Assistance from ex-service organisations

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

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

### Assistance from DVA

DVA staff can also help to complete this form.

### Completing this form

This form is in 4 parts and asks for details about:

- |  |
|--|
| <b>PART A</b> - your nominated representative, if any; such as name and contact details.   |
| <b>PART B</b> - yourself and the amount of earnings lost, when this happened and why; to be completed by the person who lost earnings, including a self-employed person. |
| <b>PART C</b> - wages lost and confirmation of details in Part B; to be completed by the employer.   |
| <b>PART D</b> - treatment provided where the veteran's absence from work was for this reason; to be completed by a treating doctor.                                      |

### Proving your identity to DVA

When lodging a **new** claim for Income Support and Compensation payments under the *Veterans' Entitlements Act 1986*, the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* or the *Military Rehabilitation and Compensation Act 2004*, before your claim can be finalised you may be required to show DVA documents that prove your identity. You must show original documents or copies that are certified as true copies of the originals. You will be contacted if it is necessary to provide these documents.

Further information about proving your identity to DVA is in the Fact Sheet, DVA06 "Proving your identity to DVA".

Applicants in payment prior to 4 January 2005 have already satisfied DVA's proof of identity requirements and do not need to again.

## Privacy Notice

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

[Read more: How DVA manages personal information](#)

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### Giving false or misleading information is a serious offence.

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

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## How to contact DVA

For information, please call the Department of Veterans' Affairs on **1800 555 254**

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State	Address	Postal address
New South Wales	Centennial Plaza Tower B 280 Elizabeth Street Sydney NSW 2001	GPO Box 9998 Brisbane QLD 4001
Victoria	300 Latrobe Street Melbourne VIC 3000	GPO Box 9998 Brisbane QLD 4001
Queensland	480 Queen Street Brisbane QLD 4000	GPO Box 9998 Brisbane QLD 4001
South Australia	Westpac House 91 King William Street Adelaide SA 5000	GPO Box 9998 Brisbane QLD 4001
Western Australia	AMP Building 140 St Georges Terrace Perth WA 6000	GPO Box 9998 Brisbane QLD 4001
Tasmania	Barrack Place 254 - 286 Liverpool Street Hobart TAS 7001	GPO Box 9998 Brisbane QLD 4001
Northern Territory	Winnellie Central 14 Winnellie Road Winnellie NT 0820	GPO Box 9998 Brisbane QLD 4001
Australian Capital Territory	2 - 6 Bowes Street Woden ACT 2606	GPO Box 9998 Brisbane QLD 4001

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**PART A****Representative's details**

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

**1 Do you wish to nominate a representative or organisation to act for you in matters relating to this application?**No  ► Go to **Question 3**Yes  ► Full name of nominated representative

Organisation (if applicable)

Address

  

POSTCODE

Telephone

Home

Work

Mobile

Facsimile

E-mail address

**2 Is the representative trained under the Training and Information Program (TIP)?**No Yes  ► To what level?**PART B****Applicant's details**

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

**3 DVA file number (if known)****4 Your surname****5 Your given names****6 Postal address**  

POSTCODE

**7 Telephone number(s)**

Home

Work

Mobile

Facsimile

E-mail address

**Grounds for applying for loss of earnings allowance**

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

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

FOR VETERANS ONLY

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

Accepted disability	Period when treated?
<input type="text"/>	/ / to / /
<input type="text"/>	/ / to / /

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

Appointment with	Length of appointment
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

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

Accepted disability	Period when treated?
<input type="text"/>	/ / to / /
<input type="text"/>	/ / to / /

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

Name of treating Doctor	Period absent from work without sick leave?
<input type="text"/>	/ / to / /
<input type="text"/>	/ / to / /

FOR OTHERS ONLY

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

Date of appointment	Purpose of appointment
<input type="text"/>	<input type="text"/>

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

Reason for absence
<input type="text"/>

**Period for which loss of earnings is claimed**

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

From	<input type="text"/>	To	<input type="text"/>
From	<input type="text"/>	To	<input type="text"/>

**Self-employed declaration**

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

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


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

\$ <input style="width: 90%;" type="text"/>	Please provide your last three Business Activity Statements with this form.
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**Declaration**

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

at  
*address of business*

	POSTCODE

and my normal working hours are:

<i>Start and finish times (e.g. 8 am to 5 pm)</i>	<i>Days of the week (include weekends, e.g. Monday to Friday)</i>
<input style="width: 40%; text-align: center;" type="text"/> am/pm to <input style="width: 40%; text-align: center;" type="text"/> am/pm	<input style="width: 100%;" type="text"/>

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

**YOUR SIGNATURE**

	Date
	<input style="width: 80%;" type="text"/>

**Other details (for ALL applicants)**

**12** Have you received or are you entitled to receive, or are you claiming:

- any benefits from Centrelink;
- any benefits from Comcare or MCRS under the DRCA or MRCA;
- any payments from a third party, such as income protection payments;

in respect of these loss of earnings?

No <input type="checkbox"/>			
Yes <input type="checkbox"/>	Amount received	Period	
	\$ <input style="width: 80%;" type="text"/>	<input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/>	to <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/>
	Type of payment	<input style="width: 100%;" type="text"/>	
	Insurance company name	<input style="width: 100%;" type="text"/>	
	Centrelink reference (if applicable)	<input style="width: 100%;" type="text"/>	

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

Veteran's or dependant's full name	Veteran's or dependant's DVA File No.
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Veteran's or dependant's address	
<input style="width: 100%;" type="text"/>	POSTCODE

**Declaration and consent**

**NO REPRESENTATIVE APPOINTED**

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

I declare that the details I have given in this form are complete and correct.  
I am aware that giving false or misleading information is a serious offence.  
I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.  
I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

**YOUR SIGNATURE**



Date

/ /

**REPRESENTATIVE APPOINTED**

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

I declare that the details I have given in this form are complete and correct.  
I am aware that giving false or misleading information is a serious offence.  
I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.  
I authorise the nominated representative or organisation to act for me in respect of this application and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:

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

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

**YOUR SIGNATURE**



Date

/ /

**PHYSICAL OR MENTAL INCAPACITY**

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



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

Your full name

Address

POSTCODE

Telephone

Home

[ ]

Work

[ ]

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

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

Type of document

I have provided DVA with a copy of

**YOUR SIGNATURE**



Date

/ /

**PART C****Unpaid absence from work report**

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

**14 Name of employee/applicant**

**15 Occupation**

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

Start & finish times (e.g. 8am to 5pm)	Days of the week (incl. weekends) (e.g. Monday to Friday)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

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

Period of <b>unpaid</b> absence	No. of hours	Basic hourly wage rate	Penalty rate	Overtime rate	TOTAL wages lost
<input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>

**Sick leave credits**

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

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

No  ▶ Please give reason

Yes

  
  



Please attach copies of any relevant medical certificates

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

 days/hrs

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

 days

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

 /  /

**Compensation details**

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

No

Yes  ► Amount received

\$

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

Insurance company

**Employer's details**

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

**24** Your position title

**25** Your contact phone number

[  ]

**26** Business name

**27** Business address

POSTCODE

**28** Signature

**YOUR SIGNATURE**



Date

/  /



**PART D****Treating doctor report**

To be completed by a treating doctor in respect of the veteran's absence from work for treatment purposes.  
 The Department will pay for this service according to the *Schedule of Fees*. An account, showing the time spent in consultation, must be lodged before payment can be made.

**29 Veteran's full name**

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


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

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

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


**32 Did you provide treatment for the above condition(s)?**No  ► Please go to **Question 33**Yes  ► Please provide details

	Condition 1	Condition 2
Details of <b>treatment</b> provided	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Dates of consultations, including hospitalisations	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Period(s) off work authorised by yourself	<input type="text"/> / / to / /	<input type="text"/> / / to / /
	<input type="text"/> / / to / /	<input type="text"/> / / to / /
How is treatment preventing the veteran from working?	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

If insufficient space, please attach a separate sheet

**33 Did you arrange treatment for the listed condition(s) with specialists or other health workers?** No   
 Yes  ► Please provide details

	Condition 1	Condition 2
Provider's name	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
Address	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 45%; height: 20px;" type="text"/> POSTCODE	<input style="width: 45%; height: 20px;" type="text"/> POSTCODE
Details of <b>treatment</b> provided	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
Dates of consultations, including hospitalisations	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
Period(s) off work authorised by provider	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
How is treatment preventing the veteran from working?	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>

*If insufficient space, please attach a separate sheet*

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

No

Yes

▶ Please provide details of the specialists or other health worker(s) who provided the treatment if not provided or arranged by yourself.

Name	Address	Profession
<input type="text"/>	<input type="text"/>	<input type="text"/>
	POSTCODE	
<input type="text"/>	<input type="text"/>	<input type="text"/>
	POSTCODE	
<input type="text"/>	<input type="text"/>	<input type="text"/>
	POSTCODE	

**35** Your name

**36** Address

<input type="text"/>	POSTCODE
<input type="text"/>	<input type="text"/>

**37** Telephone number

**38** Signature



Date