

## WORKER'S COMPENSATION EMPLOYER'S REPORT

You must lodge this form with Allianz within **three working days** of being notified of an injured persons claim.

### 1. Employer Details

Legal Entity / Name

Trading Name

Address

  


Postal Address

  


Telephone

Fax Number

E-mail Address

Main Business or Industrial activity

Policy Number

Due Date

Risk Number

### 2. Claimant Details

Name

Address

  


Home Telephone

Date of birth

Place of birth

If Claimant has difficulty understanding English, what is their preferred language?

Relationship to employer (if any)?

Occupation (include Industrial Award designation)

Marital status.

No. Dependant children (under 16 yrs)

Is Spouse working?

 Yes  No

Is the Claimant in your direct employment?

 Yes  No

Is the Claimant a Contractor or Sub-Contractor?

 Yes  No

If Yes, give name and address of Contractor or Sub-Contractor?

Name

Address

  


Does Claimant employ labour?  Yes  No

How long has the Claimant been in your employment?

At the time of the occurrence was the Claimant working as a:

Direct Employee?

Working Director?

Contractor?

Employee or Contractor?

Sub-Contractor?

Other?

Fulltime  Parttime  Casual

If parttime or casual, nominate the regular number of hours worked on each day.

S	M	T	W	T	F	S

Describe the actual tasks carried out by the Claimant

What pre-existing condition(s) may have contributed to the condition?

Did the Claimant participate in any non-work related activities, which may have contributed to the condition?

 Yes  No

If Yes, give details

Has the Claimant completed an Application for Employment Form?

 Yes  No

Has the Claimant undergone a pre-employment medical examination?

 Yes  No

Describe any other factors, which may have contributed to the occurrence of the contribution.

**3. Accident Details**

Accident date

Time

Location

This claim is for Medical Expenses No  Yes  Weekly payment No  Yes

If Yes, complete section 4

Time Claimant commenced work on the day of the accident?   
Time Claimant usually commences work?   
Time Claimant usually finished work?

Date Claimant cease work as a result of the accident?

Has the Claimant returned to work? No  Anticipated return date   
Yes  Date returned

Was the Claimant injured as a result of their employment?

 Yes  No

Did the Claimant consume any alcohol or non-prescribed drugs in the 12 hours proceeding the accident?

 Yes  No

If Yes, give details

**4. Wage Details**

Number of days in working week

Number of hours worked per day

**First 4 Weeks**

Please provide details for the 13 weeks prior to date of injury.

- Do not include any time lost from work due to sick or annual leave or any other non-work related matter.
- Please Complete from on last page.

**Post 4 Weeks**

For the purpose of making weekly payments under Workers' Compensation & Rehabilitation Amendment Act for the weeks Subsequent to the first 4 weeks the Claimant is entitled to the equivalent of the Industrial Award/Agreement plus any regular above award payment excluding overtime, allowances and bonuses.

**5. Accident Description**

What was the Claimant doing when the accident happened?

What caused the accident?

Were vehicles involved in the accident?

 Yes  No

If Yes, complete claim form for Injury on the journey.

**Retain any broken or defective machinery parts**

Describe the nature and extent of the injury.

Has the Claimant ever had a similar injury?

Yes  No

Give details

Did the Claimant have any infirmity prior to the accident?

Yes  No

Give details

Was the accident a result of negligence of any person?

Yes  No

Name

#### 6. Reporting

Date Accident reported

Time

Name of person to whom the accident was reported

Position

#### 7. Other Benefits

Is the Claimant entitled to receive any allowance, benefit or compensation for this injury from any other source?

Yes  No

Give details

#### 8. Witnesses

Name

Name

*Attach a statement from each witness to this form.*

#### 9. Important

You must attach full details if:

- The Claimant violated any statutory (or other) regulation at the time of the accident.
- There was any misconduct by the Claimant (or any other party) that contributed to the accident.
- There are any special circumstances about which Allianz should be told.

#### 10. Declaration

I declare the answers given on this form are true and correct.

Signature

Date

Print name

#### 11. Employer Notice

- *Failure to lodge this form with Allianz within 3 working days of claim notification may result in you being penalised 3 days compensation.*
- *Attach employee's report and medical certificates to this form.*
- **No compensation is to be paid until authority from Allianz has been obtained**

Please return to either:

**Allianz Australia Insurance Limited**  
**PO Box K772**  
**City Delivery Centre WA 6842**

Or

**Fax to 08 9422 8497**

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Other \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						