



Claim form

# Employer's Report of Injury

## Privacy

- We need personal information to assess this claim. We will, where relevant, disclose personal information (other than sensitive information such as health information) to the employer (and any licensee, broker or agents appointed by the employer), the WA Workcover Authority, to other insurers, to our service providers (including loss adjusters and investigators) and our business partners for this purpose;
- Where relevant, to assess this claim we will also disclose personal information, including sensitive information such as health information, to the WA Workcover Authority, the employer (and any licensee, broker or agent appointed by your employer), medical practitioners, other health professionals, other insurers and reinsurers, legal representatives and other consultants. By signing this Claim Form, You consent to those organisations and other professionals collecting, and Us disclosing sensitive information for this purpose;
- A list of the type of service providers, business partners and consultants we commonly use is available on request, or on our website - go to [www.zurich.com.au](http://www.zurich.com.au) and click on the Privacy link on our home page;
- If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of this claim may be delayed or we may not accept the claim;
- We may also disclose personal information where we are required or permitted to do so by law;
- In most cases, on request, we will give you access to the personal information we hold about you;
- If you would like to find out more, you can contact us by telephone on 132 687, e-mail Us at [Privacy.Officer@zurich.com.au](mailto:Privacy.Officer@zurich.com.au) or write to "The Privacy Officer" at Zurich Financial Services Australia Limited, PO Box 677, North Sydney, 2059. Please provide details of your policy number/s and/or claim number where known.

## Employers – Please note

1. This Report of Injury must be forwarded to Zurich within 3 days of the Worker giving you a First Medical Certificate and Workers Claim Form together with those forms. Fines can be imposed for late notifications.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify Zurich when work is resumed.
3. **NO WEEKLY COMPENSATION PAYMENTS ARE TO BE MADE WITHOUT PRIOR APPROVAL FROM ZURICH AND ONLY AFTER RECEIPT OF A COVERING MEDICAL CERTIFICATE IN THE FORM PRESCRIBED UNDER THE ACT.**
4. Weekly Compensation will only be reimbursed at the rates advised by Zurich.
5. Medical accounts should be sent unpaid to Zurich.
6. **Section 84AA Employer to keep position available during workers' incapacity**  
Where a worker who has been incapacitated by injury attains partial or total capacity for work in the 12 months from the day the worker becomes entitled to receive weekly payments of compensation from the employer, the employer shall provide to the worker:  
(a) The position the worker held immediately before that day if it is reasonable practicable to provide that position to the worker; or  
(b) if the position is not available, or if the worker does not have the capacity to work in that position, a position  
(i) for which the worker is qualified; and  
(ii) that the worker is capable of performing.  
Most comparable in status and pay to the position mentioned in paragraph (a). **(Penalty: \$5000).**
7. **Section 84AB Employer to notify worker and WorkCover WA of intention to dismiss worker**  
An Employer must not dismiss a worker to whom Section 84AB(1) applies unless the employer has given to the worker and to WorkCover WA in accordance with subsection (2) a notice of intention to dismiss the worker, in the required form not less than 28 days before dismissal. **(Penalty \$2000).**
8. Section 155C requires an employer to establish a return to work program as soon as practicable if a worker's treating doctor advises the employer in writing that a program is necessary or the doctor signs a medical certificate that the worker has total or partial capacity to return to work. The employer must ensure that the establishment, content and implementation of a return to work program are in accordance with the code of practice. Under section 155D an employer may request in writing that their insurer assist in establishing a return to work program for a worker.
9. The legislative reforms will result in significant changes to an organisation's practices following a workplace injury.  
WorkCover have developed guidance notes to accompany the Code of Practice (Injury Management) that contains a template for an Injury Management System. The template illustrates that an injury management system can be a set of simple steps that provide for appropriate action to be taken by an employer when a workplace injury occurs.  
**Employers who use the injury management system template would meet the requirements of Section 5 of the Code of Practice. For further information visit WorkCover WA's internet site at [www.workcover.wa.gov.au](http://www.workcover.wa.gov.au) or contact the WorkCover Infoline on 1300 794 744.**
10. Please telephone Zurich if you have difficulty completing this form or any other questions.

**Employer details**

Name of Policy holder  Policy No.

Trading Name

What is your ABN  What is your ITC (Input Tax Credit)  %

Postal address  Postcode

Location address (specify number, street, suburb)

Phone No.  Fax No.

Business (type of activity or profession)

How many people do you employ (a) in total?  (b) in the Worker's Occupation?

**Employer contact person dealing with workers' compensation claim**

Name  Position

Phone No.  Fax No.

Email

Address  Postcode

**Worker's Employment details**

Full name of worker (Surname)  (First names)

Residential address  Postcode

Gender Male  Female  Date of birth  Marital Status - Married  Single  Defacto  Divorced

Date first employed  Occupation

Main tasks performed by worker

Is the worker a direct employee? YES  NO  If "NO", explain employment

Is the worker a member of the Employer's family? YES  NO  If "YES", do they reside with the Employer? YES  NO

Is the worker employed by anyone else? YES  NO  If "YES", provide name and address

Is the worker a working director? YES  NO  If "YES", are they declared on the policy YES  NO

**Injury details (Please complete all particulars)**

Date of injury  Which day of week?  Time of injury  am/pm

Date reported  Time reported  am/pm

To whom was the incident reported?

If there was a delay In reporting the injury to you what reason was given for the delay?

Address and place where injury occurred

Names and addresses of witnesses

Details of previous similar injuries

How did the injury occur and what was the worker doing at the time? (eg. slipped while walking down stairs)

Describe the worker's injury or condition (eg. laceration, dermatitis)

Which parts of the body were affected? (eg. upper left arm, right ankle)

**Compensation details**

Did the worker cease work because of the injury? YES  NO  If "YES", when?  Time  am/pm  
 If "NO", go to "Complete all particulars on page 4"  
 Has worker resumed work? YES  NO  If "YES", when?  Time  am/pm  
 What is the exact time lost: Weeks  Days  Hours  (To date of completion of form if work has not been resumed)  
 What are the normal working hours? (eg. 7.00 am to 3.30 pm Monday to Thursday; 7.00 am to 1 pm Friday)  
 Day  Day  Day  Day   
 No. of Hours worked per week

**Wage Information – (Complete only when claiming for lost time)**

**Weekly earnings for 13 week prior to incapacity**

Note: If agreed or market rate please confirm whether this was negotiated with reference to an award

Is the worker employed under (please  tick the appropriate box)  
 Federal award  State award  Registered EBA  Unregistered EBA  Agreed or market rate   
 Is the worker employed Full time  Part time  Casual  Other  Sub-Contractor  Contractor   
 Award Classification Name   
 How many hours are specified in the Award or Registered EBA as a full-time week?   
 How many hours does the worker work per week?   
 How many days are worked per week?  Are there any rostered days off? YES  NO   
 If "YES", which days?

What is the worker's weekly wage, exactly as prescribed by the relevant Award, Enterprise Bargaining Agreement, Market or Agreed Rate? Excluding shiftwork, overtime, penalty rates, tool allowance, travel allowance, site allowance, over-award payments or payments to cover expenses incurred.

Base Gross rate per week \$  What is the actual current gross weekly rate paid to the worker \$

Week ending dd/mm/yy	Ordinary hours	Base hourly rate \$	Overtime paid \$	Bonuses / Allowance (tools, site etc) \$	Over award payment \$	Annual leave \$	Sick leave \$	Public holidays \$	Rostered days off \$	Other days \$	Gross weekly earnings \$
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
<b>TOTAL GROSS EARNINGS</b>											<b>\$</b>

Note: If the worker is not employed under an award classification or Registered EBA, please provide details of the total gross earnings (excluding GST, leave loading) paid to the worker up to the length of service but not exceeding 12 months prior to the date of injury.

Gross Earnings \$  The total number of weeks worked?   
 If not 52 weeks please confirm the dates worked  to  Number of weeks worked

**Safety Equipment (where applicable to the tasks which resulted in the injury)**

Had the worker been provided with safety equipment or clothing at the time of the incident eg. glasses, boots, harnesses? YES  NO

If "YES", was it being worn/used at the time of the incident? YES  NO  If "NO", why?

\_\_\_\_\_

**Injury Management / Rehabilitation (Please complete every particular in this section)**

Do you have a written established injury management system, in accordance with the injury management code of practice and section 155B of the Act YES  NO

If "NO", state why

\_\_\_\_\_

Do you have a written established return to work program for injured workers, and are you able to implement a return to work program in accordance with the injury management code of practice and section 155C(1)(3) of the Act? YES  NO

If "NO", state why

\_\_\_\_\_

Do you have any alternative duties the worker can perform until pre-injury fitness is achieved? YES  NO

Do you require further information to assist in establishing an injury management system or return to work program? YES  NO

**Contact details of person responsible for day to day management of injury management systems within the workplace**

Name  Position   
Phone No.  Fax No.   
Email   
Address  Postcode

**Give details of other circumstances that may assist Zurich to assess the claim**

(Include queries as to the validity of the claim eg. misconduct, skylarking or pre existing medical conditions contributing to the injury or incident)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employer Declaration**

**Commencement/Termination date Section 930** (Please complete if you have not clearly date stamped confirming when you first received the workers claim form or first medical certificate).

The date a completed and signed (Form 2B) worker's claim form was first received? Date

The date a first medical certificate supporting the claim lodged was first received? Date

I (print name and position)

declare that the details above are true and correct in every particular.

Signature of employer or authorised person  Date