WORKERS' COMPENSATION EMPLOYER'S REPORT

Allianz

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

1 Employer Details

Legal Entity / Name

Trading Name

ABN Number

ITC % Entitlement

%

Address

Postcode:

Postal Address

Postcode:

Telephone ( )

Fax Number ( )

E-mail Address

Main Business or Industrial Activity

Policy Number

Due Date / /

Risk Number

2 Claimant Details

Name

Physical Address

Postcode:

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 (including Industrial Award designation).

Marital Status

No. Dependant Children (under 16 years)

Is Spouse working?

No ☐ Yes ☐

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 of Contractor? ☐

Sub-Contractor? ☐

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

Name

Address

Postcode:

Does Claimant employ labour?

No ☐ Yes ☐

Other? ☐

Describe the actual tasks carried out by the Claimant.

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

No ☐ Yes ☐

If Yes, give details.

Has the Claimant completed an Application for Employment Form?

No ☐ Yes ☐

Has the Claimant undergone a pre-employment medical examination?

No ☐ Yes ☐

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

3 Accident Details

Date of Accident / /

Time am/pm

Location

This claim is for Medical Expenses No ☐ Yes ☐

Weekly Payments No ☐ Yes ☐

If Yes, complete Section 4.

Time Claimant commenced work on the day of the accident? am/pm

Time Claimant usually commenced work? am/pm

Time Claimant usually finished work? am/pm

Date Claimant ceased 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?

No ☐ Yes ☐

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

No ☐ Yes ☐

If Yes, give details.

4 Wage Details

Number of days in working week.

Number of hours worked per day.

Is the Claimant: Full Time? ☐ Part Time? ☐

Permanent? ☐ Temporary? ☐

Casual? ☐

If part-time or casual, nominate the regular number of hours worked on each day.

S	M	T	W	T	F	S

If the claimant is paid pursuant to an Industrial Award, Work Place Agreement or Agreed Contract the following wage information is required to calculate the rate of pay.

* ***Please complete Section A on the last page.***

First 13 Weeks

Provide details for the 13 weeks wages paid prior to date of incapacity.

* Do not include any time lost from work due to sick or annual leave or any other non-work related matter.

Post 13 Weeks

For the purpose of making weekly payments under Workers' Compensation & Injury Management Act 1981 (as amended) for the weeks subsequent to the first 13 weeks the Claimant is entitled to the equivalent of the Industrial Award/EBA plus any regular above award payment and any allowance paid on a regular basis excluding overtime, allowances and bonuses.

If the claimant is paid pursuant to an Agreement including a Work Place Agreement the following wage information is required to calculate the rate of pay.

* ***Please complete Section B on the last page.***

The **Total Gross Earnings** for the 52 weeks prior to the date of injury.

* If the claimant has not been employed for the full 52 weeks please specify the full period of employment.

Please note that any wages paid on the date of injury should not be included.

5 Accident Description

What was the Claimant doing when the accident happened?

What caused the accident?

Were vehicles involved in the accident?

No ☐ Yes ☐

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

Was any other object, machinery, footwear, clothing or other item involved in the accident? If so, please provide details.

Retain any such objects or items.

Describe the nature and extent of the injury.

Has the Claimant ever had a similar injury?

No ☐ Yes ☐

If Yes, give details.

Did the Claimant have any pre-existing condition, including any injury, disease or illness prior to the accident?

No ☐ Yes ☐

If Yes, give details.

Did any third parties cause or contribute to the accident?

No ☐ Yes ☐

If Yes, please provide contact details.

If so, were there any contracts in existence between the employer and any such third parties?

No ☐ Yes ☐

6 Reporting

Date Accident Reported / /

Time am/pm

Name of person to whom the accident was reported.

Position

Date claim documents were given to the Employer by the Worker. / /

7 Other Benefits

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

No ☐ Yes ☐

If Yes, give details.

8 Witnesses

Name

Name

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 give 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 6461 4738

BOX A

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

$ **State base weekly or hourly award rate.**

State award name and classification.

Please supply documentary proof.

BOX B

$ **Total Gross Earnings**

Dates employed if NOT full 52 weeks:

From / / to / /

Please supply a detailed weekly summary of wages paid for this period.