ACT WORKERS COMPENSATION – EMPLOYERS FORM

Allianz

Before completing this form, please read the notes on the back. Print clearly and mark with a tick where appropriate. It is a legislative requirement that Employers report ALL workplace injuries within 48 hours of becoming aware of a workplace injury.
Phone **1300 360 595** for assistance with the notification process.

Policy Number | Risk No. | Cost Centre No. | Incident Number

1. Employer Details

Full Name as per Policy

Postal Address

Postcode

Contact Name | E-mail Address

Telephone Number | Fax Number

Location address of employer
(specify number, street, suburb)

Postcode

Workplace, name and location where worker is usually employed (ie, depot, branch, etc.)

Postcode

Main business activity or profession of employer

Business activity or profession of workplace where worker is usually employed

Rehabilitation or Return to Work Coordinator

Please provide any information which will assist Allianz assess the claim. Eg. Do you query the validity? If so, why? If space insufficient, please attach separate sheet.

2. Workers Employment Details

Surname of injured worker

First Name | Home Phone Number

Residential Address

Postcode

Sex: Male ☐ Female ☐

Date of Birth | Date Employed

Full Time ☐ Part Time ☐

Permanent ☐ Casual ☐

Occupation

Is the worker:

An Apprentice ☐ Trainee ☐ Volunteer ☐

Main tasks performed by Worker

If not an employee, explain relationship

Normal Working hours eg.
7am to 3.30pm Monday to Thursday
7am to 1.00pm Friday

to days

to days

Average weekly pre-incapacity hours calculated over the previous 12 months, or period of employment, if less than 12 months. Do not include overtime hours unless the overtime has been worked in a regular and established pattern.

Average weekly pre-incapacity earnings calculated over the previous 12 months, or period of employment, if less than 12 months. Do not include overtime earnings unless the overtime has been worked in a regular and established pattern.

3. Injury Details

Time of Injury

Date of Injury

Time reported to employer

Date reported to employer

To whom was the accident reported?

Full address and place where injury occurred (accident location)

Postcode

Name and address of witness if any

Postcode

Details of Previous injuries, if known

Description of accident and location. Eg. slipped while walking downstairs

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

Which parts of the body were affected? Eg. upper left arm

Hospital or Treating Doctor's name and phone number

4. Time Lost Details

Date worker ceased work

Time worker ceased work am/pm

Has the worker resumed work?

Yes ☐ No ☐

Date resumed work

Time resumed work am/pm

Exact time lost – in days and hours

Days

Hours

EMPLOYERS PLEASE NOTE:

- **This form, together with the injured workers claim form, must be forwarded to Allianz CANBERRA – PO BOX 262 Canberra 2601 – within 7 days of receiving the workers claim form.**
- **The Act requires employers to report all injuries to their insurer within 48 hours of becoming aware of an injury. If this injury was not notified within 48 hours, the employer is liable for weekly compensation payments until Allianz is notified.**
- **A claim for weekly benefits will only be considered if accompanied by a medical certificate providing the doctors opinion as to the causation of the injury, the relationship of the injury to employment, the diagnosis, prognosis and recommended treatment.**

I, (print name and position)

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

Signature of Employer or authorised person

Date

N.B. Please contact your local Allianz Branch if you require any assistance in completing this form.