Employer's report of injury
ACT

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

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www.qbe.com

Claim number | *Office use only*

Before completing this form, please read the following information. Complete in block letters in the white areas and mark with a tick where appropriate.

Important information for employers

1. This notice of claim must be forwarded to QBE within seven days after lodgement of claim by worker. This also applies to any documentation received in respect to the claim.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify us immediately if the worker returns to work.
3. Compensation payments are to be made upon receipt of a medical certificate in the form prescribed under the Act.
4. Payments will be made to you unless special arrangements are made.

Employer's details

Full name as per policy | Policy number

Telephone | Facsimile | ABN

Postal address | State | Postcode

Site address *(specify number, street, suburb)* | State | Postcode

Name and location where worker was employed *(depot, branch etc.)*

State | Postcode

Business activity or profession

Name of rehabilitation co-ordinator

Email | Cost centre number

Injured worker's details

Surname or family name | *Given name*

Worker's name

Residential address | State | Postcode

Contact numbers | Telephone | Mobile

Email

Date of birth / / | Sex: Male Female

Date employed / / | Employed as: Permanent or Casual Full-time or Part-time

Occupation | Hours worked

Main task performed by worker

Normal working hours *(eg. 7.00am to 3.30pm Monday to Thursday: 7.00am to 1.00pm Friday)*

Is worker a direct employee? If 'No', explain employment Yes No

Injury details

Where did the injury occur? At work | During a break at work | Away from work during a recess | Vehicle accident while working | Travelling to or from place of employment

Date of injury / / | Time of injury am pm

Date notice given / / | Time notice given am pm

To whom was the accident reported

If you stopped work, date stopped / / | Time stopped work am pm

Address and place where injury occurred

How did the injury occur and what were you doing at the time? *(eg. slipped while climbing a ladder)*

Injury details

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

Which parts of the body were affected? *(eg. upper arm, lower back)*

Details of previous related injuries if known

Names and addresses of witnesses *(if any)*

Give details of other circumstances which would assist the insurer to assess the claim *(eg. Do you query the validity of the claim? If so, why?)*

In my opinion

Time lost details

Date worker ceased work?	/ /	Time worker ceased work?	am pm	

Has the worker resumed work? Yes No

If 'Yes', date resumed work	/ /	Time resumed work	am pm	

Exact time lost to date

Days		Shifts		Hours		Award hours worked per week		
Days worked per week						Rostered shifts/hours/days off		

Wage details

When calculating the worker's average weekly earnings, please include shift work, overtime, penalty rates, over-award payments, or payments to cover expenses incurred.

What is the average weekly earnings per week paid to the worker?

Is the worker: An Apprentice Trainee Indentured *(including overtime, bonuses etc.)*

Which year of apprenticeship is the worker in? 1st Year 2nd Year 3rd Year 4th Year

What is the average number of hours worked per week?

Rehabilitation

Has the worker resumed work under the guidelines of a rehabilitation plan? Yes No

What rehabilitation plan has been set down for an early return to work? Give details

Name of Rehabilitation Coordinator

Statutory declaration

Privacy legislation protects personal and sensitive information on this form that could reasonably identify an individual. QBE will only use or disclose personal information for purposes that would reasonably be expected during the claim process. We may need to share information with our agents or service providers who may also be involved with your claim. This could include rehabilitation providers, medical practitioners, investigators, solicitors, other insurers, and national and overseas reinsurers. If we need to use the information for another purpose, we will ask you for your permission first. You will be provided with the opportunity to access your personal information (some restrictions and costs may apply). In respect of any complaint that you may have regarding your personal information, QBE will provide you with our dispute resolution procedures. If you would like any further information or if you have any concerns about how QBE is managing your personal information, please contact the Claims Compliance Manager by email: compliance.manager@qbe.com or by telephone: 02 9375 4656.

Date claim received from worker / /

I (print name, position)

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

Signature of Employer or authorised person **X** Date / /

Office use only

Approval From am pm on / / to am pm on / /

Weekly rate $ Other – Pay Employer Worker

Auth/chq by / / Initial estimate $ F/U

Please return this form to QBE Workers Compensation at mywcclaim@qbe.com.