ACT WORKERS COMPENSATION – WORKERS CLAIM FORM

Allianz

Complete all questions fully and accurately, to ensure accurate decisions can be made about your claim.

Policy Number | Employer Name | Incident Number

1. Worker's Particulars

Family Name | Male ☐ | Female ☐

Given (or first) Name(s)

Date of Birth

Telephone contact number(s)

Home

Work

Mobile

Residential Address

Postcode

Interpreter Required? Yes ☐ No ☐

Language

What is your country of birth?

Marital Status

Dependant Details:

Name	Relationship	Date of Birth

2. Injury Details

How did the injury occur, and what were you doing when the injury happened? (Eg. slipped when climbing a ladder)

What part/s of your body is/are injured?

Was this part(s) of your body normal before the injury? Give details

What is the address where the injury happened? (if different to work address)

Date of Injury

Time of Injury

Did anyone see your injury? Yes ☐ No ☐

If yes, names:

Name of person at your workplace you reported the injury to

Name and position

Date reported

What's the name of your Nominated Treating Doctor?

Name

Telephone number

Other similar injuries

Have you previously suffered any similar injuries or conditions? Please give details (for example, when this happened):

YOU MUST ALSO COMPLETE THE INFORMATION ON THE BACK OF THIS FORM BEFORE THE FORM IS SENT TO THE INSURER

3. Other Employment

Do you have a second job with another employer?

Yes ☐ No ☐

Name of second employer

Contact Name | Telephone Number

What is your average weekly earnings from this job?

$

What are the average weekly hours in this job?

4. (i) Declaration

It is an offence to make false and misleading statements.

I, _____ certify that the information I have provided is correct and I understand that whilst I am in receipt of weekly payments of compensation I am obliged to immediately notify Allianz of:

(a) my commencing employment; or
(b) my commencing my own business; or
(c) any change in my employment that affects my earnings

I consent to Allianz and its appointed service providers collecting personal information about me and using it for the purpose of assessing and managing my workers compensation claim, including determining liability and whether my claim is true. I consent to my insurer disclosing my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purposes of assessing my claim. I also consent to Allianz disclosing personal information to the Workers Compensation Regulator which is authorised to use this information to fulfil regulatory functions under the workers compensation legislation.

Signature of Worker | Date

(ii) Authority

I, _____ hereby Authorise any medical practitioner or other authority to provide Allianz with any and all information regarding my medical and/or factual history in respect of the injury sustained on ___/___/___. A photocopy of this authority shall be as valid as the original.

Signature of Worker | Date

Please note: It is a requirement of the ACT Workers Compensation Act 1951 that injured workers authorise their treating doctor to provide relevant information to the insurer or employer for the purposes of injury management.

5. What to do Next

1. Make sure you have completed the front of this form.
2. Make sure you have signed the declaration and medical authority.
3. If the injury occurred on a journey – complete an Injury on the Journey form.
4. Attach medical certificates and any other claim related information. **Please note** – A claim for weekly benefits will only be considered if accompanied by a medical certificate providing the doctors opinion as to the cause of the injury, the relationship of the injury to employment, the diagnosis and recommended treatment.
5. Give this form to your Employer.

6. Date given to the employer:

Received by Employer

Name | Position

Signature | Date

7. Additional information (from either the injured worker or the Employer)