Worker's report of injury
ACT

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

Canberra Branch: Level 7, 220 Northbourne Avenue, Braddon ACT 2612. PO Box 1008, Civic Square ACT 2608
telephone 02 6201 3333 • facsimile 02 6201 3398 • DX 5669 Canberra • email mywcclaim@qbe.com
www.qbe.com

Claim number | *Office use only*

To *(employer full name)*

Complete in block letters in the white areas and mark with a tick where appropriate.
Whilst in your employ, I sustained the injury described below and elect to claim under the provisions of the ACT Workers Compensation Act.

Worker's details

	Surname or family name	*Given name*			
Worker's name					
Residential address			State	NSW	Postcode
Contact numbers	Telephone		Mobile		
Email					
Date of birth	/ /	Sex: Male ☐ Female ☐			
Occupation and trade qualifications					
Married *(including defacto)* Yes ☐ No ☐		Country of birth			
Language spoken at home			Is an interpreter required?	Yes ☐ No ☐	

Dependants

Is spouse or defacto working? Yes ☐ No ☐

Full name of dependantw	Relationship to worker	Date of birth	Full time student	Residing at home
		/ /	Yes ☐ No ☐	Yes ☐ No ☐
		/ /	Yes ☐ No ☐	Yes ☐ No ☐
		/ /	Yes ☐ No ☐	Yes ☐ No ☐

Other current employers

Do you have any other employment? If 'Yes', please give details below. Yes ☐ No ☐

Full name of employer				
Address		State	NSW	Postcode

Witnesses

Name	Address

Injury details

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 *(eg. machine shop)*

What injury or injuries did you suffer? *(eg. fracture)*

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

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

Injury details

Was the body part normal before the accident? If 'No', give details. Yes ☐ No ☐

Name of treating doctor *(if applicable)*

Name of hospital *(if applicable)*

Is medical certificate attached? Yes ☐ No ☐

Other similar injuries

Have you previously suffered any similar work-related injuries or conditions?
If 'Yes', give details of the nature of the injury / condition. Yes ☐ No ☐

Journey injury *(complete only if the injury occured away from the employer's premises or while you were on a journey to or from work)*

The injury occurred while you were a Pedestrian ☐ Driver ☐ Passenger ☐

Where were you travelling from?		Time you left	am ☐ pm ☐
Where were you travelling to?			

Give details of owners of all vehicles and registration numbers.

Name	Address	Registration number

Which police station did you report to?			
Name of police officer *(if known)*		Date of report	/ /

If this was a motor vehicle accident, has a Compulsory Third Party (CTP) claim been made? Yes ☐ No ☐

Medical authority

I give permission for any medical practitioner or authority to give information relevant to this claim to my employer's Insurer or ACT WorkSafe. I agree that a photocopy of this authority shall be as valid as the original. I agree that while I am receiving weekly payments of compensation, I will notify my employer's insurer if:

- I start employment with some other person
- I start my own business
- There are changes in my employment affecting my earnings.

Signature X Date / /

Statutory declaration

Privacy legislation protects personal and sensitive information on this form that could reasonably identify you to another person. QBE will only use or disclose your personal information for purposes that would reasonably be expected during the claim process. We may need to share your 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.

You must make this declaration before one of these:

A postmaster or person in charge of a Post Office, magistrate, justice of the peace, barrister or solicitor, school head teacher, member of the police force, medical practitioner, notary public, commissioner for declarations, minister of religion, member of the Legislative Assembly or the Parliament.

To the best of my knowledge and belief, all the information given in this form is true and correct.

Signature of worker X

Declared at on the of 20

Name and title of witness

To be completed by employer

Date you received this claim / /

Signature of employer X Date / /

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