

Claimant Name

Date of Injury

Claim No.



WORKCOVER AUTHORITY OF NEW SOUTH WALES

EMPLOYER INJURY CLAIM REPORT

FOR HELP COMPLETING THIS FORM OR FOR MORE INFORMATION CONTACT

- Your WorkCover Agent
- The WorkCover Information Centre on: 13 10 50

AS THE EMPLOYER YOU NEED TO

- ✓ Notify your Agent within 48 hours of an injury, or in the case of serious incidents, notify WorkCover immediately.
- ✓ Complete a claim form if your Agent has requested you provide one by answering all indicated questions.
- ✓ Sign the employer's declaration on page 3 of this form.
- ✓ Attach a copy of the *WorkCover Medical Certificate* (if the worker's doctor has provided one) to this form.
- ✓ Keep a copy of all documents including a copy of this form for your records.
- ✓ Send this completed form, the completed *Worker's Injury Claim Form* and any *WorkCover Medical Certificate* to your Agent within 7 days after receiving them from your worker – or you may be financially penalised.
- ✓ Make notification within 5 days after you become aware of the injury, otherwise an excess will apply.
- ✓ Continue to pay the worker weekly payments in accordance with the notice provided by your Agent.
- ✓ Participate with your Agent in developing an injury management plan.
- ✓ Provide suitable duties for the worker (unless not reasonably practical).

GETTING YOUR WORKER BACK TO WORK

- **Talk with your worker about developing a return to work plan.**
- **Talk to your worker's nominated treating doctor about what duties your worker does and what parts of their work (or other available duties) the worker could do, taking into account their injury.**
- **Talk to your Agent about what support is available to help your worker return to work and overcome their injury as quickly as possible.**

YOUR WORKER'S RESPONSIBILITIES

- To notify you that they've been injured at work as soon as possible and complete the injury register at the workplace.
- To see their nominated treating doctor who may provide a *WorkCover Medical Certificate*.
- To give you the completed *Workers' Injury Claim Form* and any *WorkCover Medical Certificates* as soon as possible after being injured. If your worker or their representative has difficulty giving you their claim form or any *WorkCover Medical Certificates*, or you refuse to take receipt of these documents, the worker has the right to lodge the claim directly with your Agent or WorkCover. The worker can also notify your Agent or WorkCover directly by telephone.
- To work with you to develop a return to work plan (if required).
- To comply with their injury management plan and return to work plan.

Please note that there are penalties for providing false or misleading information in relation to this claim.

Your Agent will write to you and advise you if provisional liability has been accepted or declined. This decision will be made within 7 days of notification of injury to the Agent. The acceptance of provisional liability by the Agent is not an admission of liability. Provisional liability allows an Agent to make early payments for wages and medical expenses to the worker. Your Agent will then advise you if claim liability has been accepted or declined within 21 days.

To find out more about the process of making a claim, your employer return to work obligations and how you can assist your worker return to work, talk to your Agent or refer to the back of this form for a list of relevant publications or visit the website at www.workcover.nsw.gov.au

Should you experience difficulty once the claim has been submitted and you would like assistance call the Claims Assistance Service on 13 10 50.



EMPLOYER INJURY CLAIM REPORT

Please indicate in which State you want to lodge this claim:

☐ New South Wales ☐ Queensland ☐ Victoria

1 EMPLOYER'S DETAILS

Legal name

Trading name

Employer's scheme registration number

eg. WorkCover Employer, Policy, or Employer Registration Number

Employer's reference number *(Your reference)*

** This question is required for NSW claims*

** Policy period of insurance*

 / / to / /

Street address

Suburb

State

Postcode

Postal address

Australian Business Number

ACN/ARBN

Division

Cost Centre

What is the main business activity at the incident site?

Name, position, and daytime contact number of employer contact

Name and daytime contact number of the return to work coordinator (if any)

Address for correspondence relating to this claim

Postal address

State

Postcode

Employer contact e-mail address

If you need an interpreter, what language do you speak?

When did you receive the worker's completed claim form?

 / /

When did you receive the worker's first medical certificate?

 / /

2 WORKER'S DETAILS

Family name

Given names

Street address

Suburb

Postcode

Daytime contact phone number/s

 M W H

Date of birth

 / /

Gender

☐

Male

☐

Female

3 WORKER'S EMPLOYMENT DETAILS

Street address of the worker's usual workplace

Suburb

State

Postcode

This question is required for NSW claims

How many workers are employed at this workplace?

This question is required for Victorian claims

Workplace number for worker's usual workplace

If the incident did NOT happen at one of your workplaces, please give the name of the employer responsible for the workplace

Employer's name

What is the worker's usual occupation?

What are the main tasks performed by the worker in their usual occupation?

Which of the following apply to the worker?

(Please tick all relevant boxes)

☐

Full-Time

☐

Part-Time

☐

Casual

☐

Student

☐

Contract

☐

Trainee

☐

Agency worker

☐

Volunteer

☐

Permanent

☐

Temporary

☐

Seasonal

☐

Jockey

Other?

When did this worker start working for you?

 / /

** These questions are required for NSW and QLD claims*

Is the worker employed under any of the following?

☐

Federal award

☐

Registered industrial agreement

☐

State award

☐

No agreement or award

☐

WCA Jobcover Program

☐

Registered enterprise agreement

* What is the title of the award or agreement?

What is the worker's minimum weekly wage?

As specified by the award or agreement

\$

4 WORKER'S RETURN TO WORK DETAILS

If the worker has returned to work, please provide the date

 / /

What duties are they doing?

☐

Full

☐

Suitable/Modified

How many hours do they work each week? hrs

How many days have been lost? days hrs

Have you provided the worker with a return to work plan, taking into account the injury/condition?

Please attach a copy of the return to work plan or agreement, or please explain why you have not provided a plan.

If the worker has not returned to work, do you know of any issues that would delay or prevent a return to work?

5 CLAIM CONFIRMATION DETAILS

Do you agree that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct? ☐ Yes ☐ No

Do you accept that your worker has an injury/condition which is work-related and occurred while in your employment? ☐ Yes ☐ No

Note: If you agree the injury is work-related, and believe that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct, you do not need to complete the remainder of this form except for section 9, which MUST be completed. Otherwise, please complete any relevant questions in sections 6, 7 and 8 of this Report.

6 WORKER'S EARNING DETAILS

Please complete this section if you wish to claim for weekly payments

How many standard hours did the worker work each week before being injured? *Exclude overtime* hrs

What were the worker's usual working hours?

For example, Monday to Friday, 8.30 am to 5.30 pm

What was the worker's usual gross hourly rate? \$
Exclude overtime & shift allowances

What was the worker's usual gross weekly earnings? *Exclude overtime & shift allowances* \$

Please provide details of any overtime or shift work

Average weekly overtime hrs \$

Weekly shift allowance \$

Please provide payroll records covering the 12 months prior to injury

7 INCIDENT DETAILS

What is the worker's injury/condition, and which parts of the body are affected?

What happened and how was the worker injured?

What is the street address where the incident occurred?

Suburb

State

What date and time did the injury occur?

 / / AM
 PM

What date and time did the worker first cease work?

 / / AM
 PM

Which of the following incident circumstances apply?

- ☐ While working at the usual workplace
☐ While working away from the usual workplace
☐ During a meal-break or authorised recess at work
☐ While away from work during a recess
☐ Travelling to or from work*
☐ A motor vehicle accident while working*

* For NSW incidents a journey claim form must also be completed

If the injury was the result of driving or using a motor vehicle or the use of public transport, please provide the registration number/s of any vehicles involved

State

Has the worker had a similar injury/condition or personal injury claim before that relates to this injury/condition?

Please give details, including claim numbers

When did the worker report the injury to you?

 / /

Who was the injury reported to?

What are the names and daytime contact details of any witnesses?

Do you believe that the injury/condition was caused or contributed to by the worker, or a third party such as a manufacturer or supplier? *Please give details if relevant*

8 ADDITIONAL INFORMATION

Do you want to provide any additional information that may assist in the determination of liability or the management of this claim? *eg. Do you dispute liability, and, if so, why?*

9 EMPLOYER'S DECLARATION

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Signature of employer's representative Date

 / /

Name

Position

INFORMATION FOR EMPLOYERS AND RETURN TO WORK COORDINATORS

RETURNING YOUR INJURED WORKERS BACK TO WORK

- If your worker has any capacity for work, a return to work plan must be developed.
- The return to work plan should be regularly reviewed and updated as your injured worker's condition changes – as a guide, the plan should be reviewed at least monthly in consultation with your injured worker and their nominated treating doctor.
- If you need assistance with return to work and identifying suitable employment, contact your WorkCover Agent immediately. Steps to facilitate the return to work will include discussing return to work options with the workers nominated treating doctor and may include assistance from an occupational rehabilitation provider, modifying the worker's duties or hours, providing special equipment.
- The return to work plan should be signed by all parties to indicate their agreement and copies provided to them.

FURTHER INFORMATION

- Return to work plans and general information can be downloaded from www.workcover.nsw.gov.au
(Particularly under Publications/WorkersComp/InjuryManagement)
- Contact your Agent for further advice regarding return to work planning and preparation.

RTW PUBLICATIONS, FORMS AND INFORMATION SHEETS AVAILABLE ON THE WEBSITE

- *Employers Guide: What to do if an Injury Occurs*
- *Guidelines for Employers Return to Work Programs*
- *Workers Compensation Injury Management Fact Sheets*
- *Suitable Duties: Information for Employers and Injured Workers*
- *Guidelines for claiming workers compensation benefits*
- *Your recovery and return to work after a work place injury*

Allianz Australia Workers' Compensation (NSW) Limited
As agent for the NSW WorkCover Scheme ABN 83 564 379 108

Please send your claim form to:
GPO Box 5429, Sydney NSW 2001
Fax 1300 130 665