

First contact notification

(Workers Compensation excluding QLD, SA & VIC)

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



NOTE: You will also need to complete a claim form and submit it to QBE if this notification is likely to give rise to a claim for compensation. Claim forms are [available on our website](#). For assistance please call: +61 2 9375 4444 or see the [Help section](#) on our website. Email form to: mywclaim@qbe.com, or use the 'Submit Form' button.

Please fill out the form below as complete as possible.

Injured worker details

| | | | | |
|---|------------|--|---|----|
| | First name | | Last name | |
| Name* (Block letters) | | | | |
| Gender* | Male | Female | Date of birth* | |
| Postal address* | | | | |
| | | State | Postcode | |
| Occupation* | | | | |
| Home number* | | Work number | | |
| Mobile | | Email | | |
| Worker's average earnings (last 12 months)* | | | | |
| Award rate | | Preferred language | | |
| Currently off work* | Yes | Do you expect more than 5 working days off for this injury?* | Yes | No |
| | No | | Notification only (no lost time or medical costs) | |

Employer details

| | | | |
|--|-----|--------------------|----------|
| Business name* | | QBE policy number* | |
| Phone number* | | Mobile | |
| Fax | | Email | |
| Business address* | | | |
| | | State | Postcode |
| Contact name | | | |
| Contact number | | Cost centre | |
| Wages to be reimbursed via wage reimbursement schedule?* | Yes | No | |

Medical and injury details

| | | | | | |
|---------------------------------|--|-------------------------|----------|-----------------|--|
| Date of injury* | | Date notified employer* | | Time of injury* | |
| Address of injury* | | | | | |
| | | State | Postcode | | |
| How did the injury occur?* | | | | | |
| Worker's condition* | | | | | |
| Part(s) of body affected?* | | | | | |
| Date of first medical treatment | | Time of treatment | | | |
| Doctor / Hospital | | | | | |
| | | State | Postcode | | |

Person making notification

| | | | |
|----------------|--|--------------|--|
| First name | | Last name | |
| Contact number | | Relationship | |

Note: You will be prompted to complete mandatory fields (highlighted in red) and confirm the sender details when you click on the 'Submit Form' button.