QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

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ACT Employer's Report of Injury

Claim Number	(office use only)

Before completing this form, please read the following information. Print 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 7 days after lodgement of claim by worker. This also applies to any documentation received in respect of 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 Details

Full name as per policy		Policy Number			
Telephone		Fax		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 or Rehabilitation Co-ordinator					
Cost Centre Number					

Injured Worker's Details

Surname or Family Name		Given Names	
Residential Address			
		State	Postcode
Contact Numbers	Telephone		Mobile
Sex: Male ☐ Female ☐	Date of Birth	/ /	
Date Employed	/ /	Employed as: Permanent ☐ or Casual ☐	Full-time ☐ or Part-time ☐
Occupation		Hours worked per week	
Main tasks performed by worker			
Normal working hours (eg. 7.00am to 3.30pm Monday to Thursday: 7.00am to 1pm 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				
Address and place where injury occurred				
How did the injury occur and what was the worker doing at the time? (eg. slipped while walking down stairs)				
Describe the worker's injury or condition (eg. laceration, dermatitis)				
Which body parts were affected? (eg. upper arm, ankle)				
	Is this a re-currence/aggravation of a previous injury? Yes ☐ No ☐			

Injury Details (cont.)

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

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								