GIO Workers Compensation – Western Australia

Employer's report of injury

Complete all questions, partially completed forms will be returned. (Print in block letters and circle where appropriate.)

Do you support this claim Yes ☐ No ☐

Employer details

Full name as per policy

Trading name

Policy no. WA

Telephone number ( )

Facsimile number ( )

Email address

Postal address

Suburb

State

Postcode

Name of site and/or location address where the injured person actually works

Suburb

State

Postcode

Cost centre

Business activity/profession (use 2 words or more)

Injured person's details

Surname

Given names

Address

Suburb

State

Postcode

Telephone number ( )

Date employed / /

Place of birth

Date of birth / /

Height

Weight

Sex: Male ☐ Female ☐ Employed: Full time ☐ Part time ☐ Casual ☐ Marital Status: Married/De facto ☐ Single ☐

Occupation

GIO WORKERS COMPENSATION

Injured person's details (continued)

Is the injured person a contractor or subcontractor? Yes ☐ No ☐

(If "yes", attach a copy of any written agreement or contract, together with twelve months of their invoices if applicable.)

Is she/he a director or family member? Yes ☐ No ☐

If "Yes", please tick which Director ☐ Family member ☐

If a family member, does she/he live with the Insured? Yes ☐ No ☐

Injury details

Date of injury / /

Time of injury am/pm

Date employee claim form received / /

To whom was the accident reported

Position

Date first medical received / /

Name of witness

Address of witness

State

Postcode

Location address where the injury occurred

State

Postcode

Where did the accident occur? At work ☐ During work break ☐ Away from work during a break ☐

Motor vehicle accident whilst working ☐ Travelling to or from place of employment ☐

How did the injury occur?

What was the injured person doing at this time?

Was the injured person performing his/her normal duties? Yes ☐ No ☐

If "No", why were they doing this task?

Is protective equipment/clothing required for the task? Yes ☐ No ☐

If "Yes", what type?

Was the above clothing/equipment being worn at the time of the injury? Yes ☐ No ☐

If "No", why?

Is this a recurrence/aggravation? Yes ☐ No ☐

If "Yes", provide details of previous injury including the Insurer's claim number if known?

Describe the injured person's injury or condition (e.g. laceration, dermatitis)

Which part of the body is injured (e.g. left upper arm, right ankle)

Was first aid treatment given? Yes ☐ No ☐

If "Yes", by whom?

What treatment was provided and for what period?

Name of Doctor first attended

Hospital admitted to and date

Injury details (continued)

Give details of any other circumstances that would assist GIO to assess the claim.

(Include in here queries as to the validity of the claim e.g. misconduct, skylarking or pre-existing disabilities contributing to the injury or accident.)
In my opinion:

Time loss details (show N/A if there is no lost time)

Date ceased work	Time	Date work resumed	Time	If work has not been resumed what is the anticipated date of return
/ /	am/pm	/ /	am/we	/ /

Weekly compensation (complete only if there is or will be lost time [e.g. surgery anticipated])

How many days per week? ☐ and hours per day? ☐ does the injured person work? Yes ☐ No ☐

What is the start time? ☐ and finish time? ☐ Is this the same every day? Yes ☐ No ☐

If "No", please provide details

Please show whether the injured person is employed under: 1. Industrial Award ☐ or 2. Other ☐

If option 1:

What is the full name of the Award? is it: State or Federal?

Please also complete the 13 weeks wage information below to enable us to advise you of the correct rate of pay or provide a print-out of payment records.

Week no.	Week ending	No. of hours worked	Award rate $	Overtime $	Allowances $	Other $	Total $
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
			Average (+13)	$		Grand total	$

If option 2: Please provide the total amount paid to the injured person during the 12 months immediately prior to the accident or for such lesser period as applies and ensure that the "Date Employed" is completed in the "Injured Person's details" section on page 1.

Total "wages" paid $ ☐ for ☐ weeks (please provide print out of pay records)

Rehabilitation

The Injury Management Process in Western Australia requires consultation between the employer, the medical practitioner and the injured person before the injured worker is referred to an approved rehabilitation provider for an assessment. An employer is able to authorise their insurer to act on their behalf in the consultation process with the medical doctor to support the employee in their appointment of an approved vocational rehabilitation provider for a vocational assessment.

Do you have a delegated rehabilitation coordinator? Yes ☐ No ☐

If Yes, name

Telephone no. ( )

Has injury management commenced? Yes ☐ No ☐

If Yes, what actions have been taken

Signed

Position

Date / /

Employer's declaration

I, (print name, position)

declare that the details above are true and correct.

Signed

Date / /

Employers please note

1. a. This notice of claim must be forwarded within 5 days of lodgement of claim by the injured person. This also applies to any documentation received in respect of the claim.
   b. Please attach Workers Compensation Claim Form and 1st Medical Certificate.
2. If the injured person has not resumed work at the time of lodgement of this claim, it is important that you notify the insurer immediately after the injured person returns to work.
3. No compensation or any other payments (e.g. medical) are to be made without prior written approval of the insurer.

How to return this form

- Email: wcclaimswa@gio.com.au
- Fax: 1300 553 488
- Post: WA Claims, GPO Box B50, Perth WA 6838

How to contact us

- Phone: 13 10 10
- Web: gio.com.au

Who we are

This insurance is issued by AAI Limited ABN 48 005 297 807 trading as GIO.

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