COMPENSATION CLAIM

Allianz

To: (Full Name of Employer) _____
Whilst in your employ I sustained the injury described below and I elect to claim under the provisions of the Worker's Compensation Act.

PLEASE PRINT IN BLOCK LETTERS

Policy Number	Claim Number

About the Worker

Surname	First name	
Residential Address		Postcode
Telephone No.	Sex M or F ☐	Date of Birth
Occupation and Trade Qualifications		
Married/Single?	Country of birth:	
Language spoken at home:	Interpreter required? Yes ☐ No ☐	

List of Dependants

Is spouse or defacto spouse working? Yes ☐ No ☐

Full Name of Dependant	Relationship to Worker	Date of Birth	Full Time Student (yes or no)	Residing at Home? (yes or no)

Other Current Employers

Do you have any other employment? Yes ☐	No ☐	If Yes, give details
Full Name of Employer		
Address		

What Happened?

How did the accident occur, and what were you doing at the time? (eg. slipped while climbing a ladder.)
Name and Addresses of Witnesses.

Injury Details

If you stopped work due to the injury – Date stopped work			Time
Time of Injury	AM/PM	Date of Injury	Date Notice Given
Time Notice Given	To whom was the accident reported		
Address and Place where injury occurred (eg. machine shop)			
			Postcode
What injury(ies) did you suffer? (eg. fracture)			
What parts of the body were affected? (eg. left upper arm, lower back)			
Was the part normal before the accident?	Yes ☐	No ☐	If No, give details
Name of treating Doctor			
Workcover Medical Certificate attached? Yes ☐	No ☐	Name of Hospital (if applicable)	

Please complete questions on reverse

Other Similar Injuries

Have you previously suffered any similar injury or condition? Yes ☐ No ☐ If Yes, give details	
Date of Injury	Name of Employer (if applicable)
Name of Injury	
Details of how Injury occurred	

Journey Injuries – A separate "injury on the journey" claim form must be completed in addition to this claim form.

Declaration

I, _____ hereby declare the truth of the foregoing statement and I have been informed by the Insurer and I understand that while I am in receipt of weekly payments of compensation I am obliged to forthwith notify the Insurer of;

(a) my commencing employment with some other person; or
(b) my commencing my own business; or
(c) any change in my employment that affects my earning. I am aware that it is an offence to fail to do so.

I hereby authorise any medical practitioner or other authority to provide the Insurer with any and all information regarding my medical and/or factual history in respect of injury on _____ / _____ / _____ . A photocopy of this authority shall be as valid as the original.

Signature of Injured worker _____ Date _____

To be completed by the Employer

Signature of Employer _____ Date _____

Date Claim Received _____

Notes to Injured Worker

1 This form should be completed as soon as possible after receiving a work related injury and given immediately to your employer.

2 Complete all questions fully and accurately, errors and omissions may delay payment of benefits or result in the claim being disputed.

3 To ensure prompt consideration for payment of benefits on this claim, you should attach a Workcover medical certificate as prescribed by the Act.

4 Workcover places a major emphasis on workplace-based rehabilitation, that is, the return to work as quickly and as safely as possible. You are required to seek the co-operation of your treating medical practitioner in returning to some useful employment role as soon as possible by asking for a medical certificate, as prescribed by the Act, noting restrictions and likely rehabilitation requirements.