EMPLOYER'S REPORT OF INJURY

Before completing this form, please read the notes on the back. Print clearly and mark with a tick where appropriate.
If a worker is unlikely to resume their normal work for a continuous period of more than 7 days, legislation requires Allianz must be notified within 48 hours. Phone 1300 360 595 for assistance with the notification process.

Policy Number	Risk No.	Cost Centre	Claim Number

1. Employer Details

Full name as per policy

Postal address

Postcode:

Contact name

Email address

Telephone number

Fax number

Location address of employer (specify number, street, suburb)

Postcode:

Workplace, name and location where worker is usually employed (ie, depot, branch, etc.)

Postcode:

Relevant location number

Workplace Size? (number of employees)

Main business activity or profession of employer

Business activity or profession of workplace where worker is usually employed

Rehabilitation co-ordinator

Ph:

Rehabilitation provider

2. Worker's Employment Details

Surname of injured worker i.e.: Mr./Mrs./Ms

First name of injured worker

Home phone number

Residential address

Postcode:

Language spoken at home?

Interpreter required? Yes ☐ No ☐

Sex Male ☐ Female ☐

Date of birth / /

Date employed / /

Full time ☐ Part time ☐ Casual ☐ Permanent ☐

Occupation (e.g. cook, builder's labourer, etc.)

Main tasks performed by worker

If worker is not an employee, explain relationship (e.g. contractor)

Where time lost please complete questions on rear of form.

Please complete declaration on the back.

3. Injury Details

***One of these 6 boxes must be ticked.**

Where did the injury occur?

1) Normal work	☐	2) Other/Private workplace	☐
3) Construction site	☐	4) Public thoroughfares	☐
5) Moving transport	☐	99) Other	☐

Time of injury am/pm

Date of injury / /

Time reported to employer am/pm

Date reported to employer / /

To whom was the accident reported?

Full address and place where injury occurred (accident location)

Postcode:

Names and addresses of witnesses (if any)

Postcode:

Details of previous related injuries if known

Brief description of accident & location (e.g. slipped while walking down stairs)

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

Which parts of the body were affected? (e.g. upper left arm, right ankle)

Hospital or Treating doctors name & phone number

Other circumstances to assist the Insurer assess the claim

(e.g. Do you query the validity of the claim? If so, why? If insufficient space please attach separate sheet)

In my opinion

4. Normal working hours (e.g. 7am to 3.30pm Monday to Thursday; 7am to 1pm Friday)

am/pm to am/pm Day(s)

am/pm to am/pm Day(s)

5. Complete this section only if time was lost

Date worker ceased work / / Time am/pm

Has worker resumed work?

No ☐ Yes ☐

Date resumed work / / Time resumed work am/pm

Exact time lost Days Shifts Hours

Award hours worked per week | Days worked per week | Rostered days off (eg. Monday)

6. Award Information

Is the worker employed under an Award, Registered Industrial Agreement or Enterprise Agreement?

No ☐ Yes ☐

Federal or State Award or Registered Industrial Agreement under which worker is employed

Award classification name

Award classification number grade or group

Important Note

What is the worker's current minimum weekly wage rate, exactly as prescribed by worker's classification name and number, grade or group in the Award or Registered Industrial Agreement mentioned above? EXCLUDE shift work, overtime, penalty rates, over-Award payments or payments to cover expenses incurred.

Base Award Rate per week $

What is the actual rate per week paid to worker? $

Is the worker:

An apprentice ☐ Trainee ☐ Indentured Apprentice ☐

Which year of apprenticeship is the worker in?

1st ☐ 2nd ☐ 3rd ☐ 4th ☐

If the worker is employed as a part-time or casual employee, what is the average number of hours worked per week as a casual or part-time employee?

7. Injury Management/Rehabilitation

Has worker resumed under the guidelines of a Rehabilitation or return to work plan?

No ☐ Yes ☐

*If Yes, please send a copy of the return to work plan.

8. Employers Please Note

1. This notice of claim must be forwarded within 7 days of lodgement of claim by worker. This also applies to any documentation received in respect of claim – penalty $5,500 per infringement.
2. Payment of compensation must commence within 21 days of lodgement of claim unless notice of dispute is lodged within this time period – penalty $5,500.
3. If worker has not resumed work at time of lodgement of this claim, it is important that you notify the Insurer immediately when the worker returns to work.
4. No compensation payments are to be made without prior approval of Insurer and only after receipt of a covering medical certificate in the form prescribed under the Act. All payments of weekly benefits will be made to employer unless special arrangements are made.

9. Employer Declaration

I (print name and position)

declare that the details above are true and correct in every particular.

Signature of Employer or authorised person

Date / /

(**N.B.** Please contact your local Allianz Branch if you require any assistance in completing this form)