WORKERS' COMPENSATION
Employer's Report Form

It is essential that this form be completed to enable the worker's entitlement to compensation to be promptly determined. Payments should not be commenced until authorised by us.

Please submit via email workerscompclaims@iag.com.au If claiming for medical expenses and no time has been lost, complete all questions except question 15. Please use "BLOCK" capitals.

POLICY NO.

1 Employer details

FULL NAME OF EMPLOYER

TRADING NAME OF EMPLOYER

TYPE OF BUSINESS | ABN

ADDRESS | POSTCODE

BUSINESS TELEPHONE NO. | FACSIMILE NO. | CONTACT NAME

EMAIL | MOBILE NO.

2 Worker details

SURNAME | GIVEN NAME(S)

ADDRESS | POSTCODE

WORKER'S OCCUPATION | TELEPHONE NO.

EMAIL | MOBILE NO.

Age | DOB DD / MM / YY | Married? No ○ Yes ○ | Relationship (if any) to employer

3 Accident

Date of accident DD / MM / YY | Time AM/PM | Day of week

How long had the worker worked, on the date of the accident, before the injury? HRS MINS

Date work ceased DD / MM / YY | Time AM/PM

Date first Medical Certificate received by employer DD / MM / YY at AM/PM

Date claim form received from worker DD / MM / YY at AM/PM

Was the worker affected by alcohol or drugs? No ○ Yes ○

4 Nature of injury

Report the 'Type of injury' (e.g. fracture, sprain, amputation, etc.) and under 'Part of body' report, as precisely as possible, the part of the body injured. Where multiple injuries are received, report 'Type of injury' the nature and 'Part of body' of each injury and, where known, indicate which injury is the most severe.

	TYPE OF INJURY (E.G. LACERATION, SPRAIN, ETC.)	**PART OF BODY** (E.G. HEAD, LOWER BACK, ETC.)	**SIDE OF BODY** (E.G. LEFT/RIGHT)
1			
2			
3			

Did the worker have any pre-existing injuries or disabilities of a similar nature as noted above?

No ◯ Yes ◯ ▶ Please provide details

5 Result of injury

Enter the result as known at the time of completing this report. '**Totally unfit**' relates to claims where the worker is considered to be totally incapacitated for any type of work. '**Partially unfit**' relates to claims where the worker is fit to undertake restricted duties either on a part time or full time basis.

Please tick (✓) in the appropriate box. Fatal ◯ Partially unfit ◯ Totally unfit ◯ No time lost ◯

Has the worker resumed work? Yes ◯ ▶ Date D D / M M / Y Y

No ◯ ▶ Estimated period of incapacity Weeks Days

Have you any other duties which the worker could perform until he/she can resume his/her pre-injury duties?

No ◯ Yes ◯ ▶ Please provide details

6 Cause of accident

Indicate with a tick (✓) the occurrence that gave rise to the accident.

a. Undertaking normal duties – Normal Workplace ◯

b. Undertaking normal duties – Not normal workplace ◯

c. Undertaking normal duties – Road Traffic Accident ◯

d. Commuting/Journey ◯

e. During meal or other work break – Normal Workplace ◯

f. During meal or other work break – Not Normal Workplace ◯

g. Other Duty – please specify

7 Address where accident took place

Address POSTCODE

Was worker working at your premises or elsewhere? If working elsewhere, please provide full details of the occupier/owner of the premises where they were injured.

8 Department/section where worker was employed (e.g. welding shop)

9 State the actual process in which the worker was engaged at the time of accident

(e.g. cleaning machinery, ploughing, etc.)

10 Describe concisely all the circumstances of the accident

Ensure that the type of accident and the agency causing it are detailed

Type of accident - is the manner in which the injury occurred (e.g. fall, struck by falling object, caught in or between objects, contact with harmful substances, etc.)

Agency - refers to the working environment (machine, means of transport, substance, etc. causing the accident, e.g. conveyor failed.)

11 Please indicate whether

	No	Yes
a. Any machinery/equipment was involved in the accident?		
b. There was any breach of any statutory or other regulations at the time of injury.		
c. There was any serious and wilful misconduct on the part of the worker which contributed to the injury.		
d. The injury was caused by the negligence of any person.		
e. You agree with the details of the occurrence as provided on the Workers' Compensation Claim Form?		

a. Any machinery/equipment was involved in the accident?

If **Yes**, please identify the machinery: please provide a full and precise description of the machinery/equipment and who owned the machinery/equipment?

b. There was any breach of any statutory or other regulations at the time of injury.

If **Yes**, please provide details

c. There was any serious and wilful misconduct on the part of the worker which contributed to the injury.

If **Yes**, please provide details

d. The injury was caused by the negligence of any person.

If **Yes**, give details

e. You agree with the details of the occurrence as provided on the Workers' Compensation Claim Form?

If **No**, give details

12 Reporting of accident

Name of person to whom the accident was reported

Date reported D D / M M / Y Y Time AM/PM Occupation

13 Witness/Co-worker details

Name of witness/co-worker Employed by

ADDRESS OF WITNESS/CO-WORKER POSTCODE

OCCUPATION

If more than one witness, please attach a list on a separate page.

14 Employment details

Date first employed DD / MM / YY

Indicate with a tick (✓) the days usually worked each week.

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

State standard number of hours worked: Per day HRS MINS Per week HRS MINS

Is this worker subject to a VISA? No Yes ▶ What type of visa? e.g. S457

1. Was the worker directly employed? (i.e. not a contractor or employee of a contractor) Yes No ▶ Please provide details

2. Which of the following covers the status of the worker's employment?

Full time No. of hours per week

Part time No. of hours per week

Casual The number of weeks he/she has worked for you over the past year

Seasonal Length of season in weeks over 12 month period

Working Director

15 Worker's earnings

To enable us to calculate this worker's weekly compensation rate please provide details of their past earnings in the form of **payslips**.

For award workers we require 13 weeks past earnings before the date of incapacity. If employed less than 13 weeks, we only require the past earnings over the period of employment with you. You will also need to complete the details of the Award or Agreement requested below.

For non-award workers we require 12 months past earnings before the date of injury including all bonuses and allowances. If employed for less than 12 months, we only require the past earnings over their period of employment including the number of weeks employed by you.

Award or Enterprise Agreement

Name of Award or Enterprise Agreement

Base Award Rate and Hours

16 Additional earnings

Does the injured person work for anyone else?

No Yes ▶ Please provide details

NAME

ADDRESS POSTCODE

CONTACT TELEPHONE HOURS WORKED RATE OF PAY

17 Employer's signature

SIGNATURE OF THE EMPLOYER DATE DD / MM / YY OFFICIAL POSITION

NOTE: This form is to be signed by a person (other than the injured worker) authorised by the employer

18 Employer electronic funds transfer authority

The following authorisation authorises WFI to credit the nominated bank account in connection with payments relating to this claim.

This authority remains in force for the duration of the claim unless revoked in writing.

Please provide the following information:

FULL NAME

POSTAL ADDRESS

POSTCODE

CONTACT TELEPHONE

FACSIMILE

EMAIL

BANK NAME

ACCOUNT NAME

ACCOUNT NUMBER

BSB NUMBER

:

Please send confirmation of EFT payments by (select one)

POST ◯ FACSIMILE ◯ EMAIL ◯

I/We authorise, and request, WFI to credit the above bank account number with any amounts in connection with the claim number stated.

SIGNED

DATE

D D / M M / Y Y

SIGNED

DATE

D D / M M / Y Y

Any personal information you provide to us will be collected, stored, used and disclosed in accordance with our Privacy Policy located at www.wfi.com.au/privacy. Additionally, any sensitive information will only be used for the primary purpose for which it is collected. If you cannot access our Privacy Policy through our website, please contact us on 13 15 32 and we will send you a copy.

Insurance Australia Limited ABN 11 000 016 722 AFSL 227681 trading as WFI (WFI)
46 Colin Street West Perth WA 6005 PO Box 77 Welshpool DC WA 6986
Tel. 1300 934 934 Fax 1300 038 395