

IMPORTANT INFORMATION
please read this first

workers compensation

report of injury to be furnished by
employer (form 1) – western australia

Early notification

It is imperative that you notify Vero Workers Compensation immediately.

An employer can be penalised under the Workers' Compensation and Rehabilitation Act if there is a delay of more than 3 days in forwarding Workers' Compensation claims to the relevant Insurer.

You are required to complete & sign this document fully to enable regulatory compliance and to meet your contractual obligations under the Vero Workers Compensation Employers Indemnity policy.

Completion of this report does not necessarily imply that the employer admits liability or that the worker will make a claim.

Notes

No Compensation payment is to be made until the authority of the Insurer has been obtained, otherwise you may breach a condition of the policy.

Office use only
Policy Number
Claim Number

Section 1 employer's details

Name (as per employee's group certificate)

Address
Postcode

Telephone Number ()

Trading Name of Business (if different name to policy holder)

Description of Business/Operation

Employer Contact for Injury Management

Email address for contact

Section 2 worker's details

Surname

Other names

Date of Birth / / Age years

Address
Postcode

Telephone Number ()

Occupation

Marital Status

When did the injured person enter your employment?
/ /

Was the injured person a working director?
No Yes

Was the injured person in your **DIRECT** employment?
Yes

No Please ensure Supplementary Sub-Contractor's Questionnaire is completed.

Is the injured person in the service of a contractor or a sub-contractor?
Please give name and address of such contractor or sub-contractor

Contractor's Name

Contractor's Address
Postcode

Section 3 wages details

WorkCover requires the following information on all claims including no time lost

Is the Worker (please tick one)

Full Time Part Time
Permanent Casual

Is the injured person a shift worker

No Yes

Number of hours normally worked per week

Average hours worked (casuals and part-time)

Please advise the date you received the claim form from the worker:

Date / /

Please advise the date you received the first medical certificate:

Date / /

Weekly payments are now capped, this is indexed annually. There is a step down in weekly payments after the first 13 weeks,

Workers whose earnings are prescribed by an Industrial Award including an Enterprise Bargaining Agreement, an Enterprise Order or General Order, an Industrial Agreement and a Certified Agreement).

First 13 weeks

The rate of weekly earnings payable under the relevant award plus any over award or service payment, overtime, bonuses and allowances, averaged over the 13 weeks prior to the date of incapacity.

\$

14th week onwards

The award plus any:

- over award or service payments paid on a regular basis
- any regularly paid allowance related to the number or pattern of hours worked
- any other allowance prescribed by the regulation.

Overtime is excluded.

\$

State the name of the Award:

Workers whose earnings are **NOT** prescribed by an award.

First 13 weeks

The workers average weekly earnings over the period of 52 weeks, ending on the day before the date of disability (includes overtime and any bonuses or allowances).

\$

14th week onwards

85% of the above mentioned amount.

\$

Section 4 incident details

Date / / Hour am/pm

Place

Date incident first reported / /

At what time did the injured person commence duties on the day of injury?

Hour am/pm

What were the scheduled hours of work for the injured person on the date of incident? Start am/pm Finish am/pm

Is the claim for medical expenses only? (No Time Lost)

No Yes

When did the injured person cease work as a result of the injury?

Date / / Hour am/pm

When did the injured person resume work (if applicable)?

Date / / Hour am/pm

Is this on a restricted basis?

No Yes

If injured person has not resumed work, when is it expected they will do so?

Date / / Hour am/pm

Was the injury sustained in the injured person's course of employment with you?

No Yes

Was the injury sustained as a result of an incident involving a registered vehicle?

No Yes Please ensure Journey Claims Form is also attached (Form 4) (available from Vero Workers Compensation)

Was the injured person at the time performing their usual duties?

No Yes

State precisely what the injured person was doing when the incident happened

Please describe how the incident occurred?

Section 5 injury details

Nature and extent of injury

Has the injured person ever suffered a similar injury?

No Yes Please provide details

Did the injured person complete a pre-employment medical or application, if so; did the injured person advise you of any similar injury in their previous employment?

No Yes Please provide details

On the pre-employment application, or to your knowledge, has the injured person previously had a worker's compensation claim?

No Yes

In your opinion could the incident have been avoided by:

(a) An action on behalf the injured worker? No Yes

(b) Any other factors or 3rd parties actions? (eg machinery repairs)

Name and occupation of person to whom the incident was reported to?

Date / / Hour am/pm

Names of anyone with knowledge of the incident

Section 6 declaration

Note: This form is to be signed by a person authorised to do so on behalf of the insured *other than* the injured person.

Signed

Date / /

Name of signing officer (please print)

Position

On behalf of the employer we/I believe:

Further investigation is required

This page has been left blank intentionally.