

# Employer's Report of Injury



ZURICH

CLAIM NO.

## Privacy

- We need personal information about you to assess your claim. We will, where relevant, disclose your personal information (other than sensitive information such as health information) to your employer (and any licensee, broker or agents appointed by your employer), the WA Workcover Authority, to other insurers, to our service providers (including loss adjusters and investigators) and our business partners for this purpose;
- Where relevant, to assess your claim we will also disclose personal information, including sensitive information about you such as health information, to the WA Workcover Authority, your employer (and any licensee, broker or agent appointed by your employer), medical practitioners, other health professionals, other insurers and reinsurers, legal representatives and other consultants. By signing this Claim Form, You consent to those organisations and other professionals collecting, and Us disclosing sensitive information about You for this purpose;
- A list of the type of service providers, business partners and consultants we commonly use is available on request, or on our website - go to [www.zurich.com.au](http://www.zurich.com.au) and click on the Privacy link on our home page;
- If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim;
- We may also disclose personal information about you where we are required or permitted to do so by law;
- In most cases, on request, we will give you access to the personal information we hold about you;
- If you would like to find out more, you can contact us by telephone on 132 687, e-mail Us at [Privacy.Officer@zurich.com.au](mailto:Privacy.Officer@zurich.com.au) or write to "The Privacy Officer" at Zurich Financial Services Australia Limited, PO Box 677, North Sydney, 2059. Please provide details of your policy number/s and/or claim number where known.

## Employer Details

Name of Policy holder  Policy No.

Trading Name

What is your ABN  What is your ITC (Input Tax Credit)  %

Postal address  Postcode

Location address (specify number, street, suburb)

Fax No.  Phone No.

Business (type of activity or profession)

How many people do you employ (a) in total?  (b) in the Worker's Occupation?

## Employer contact person dealing with workers' compensation claims

Name  Position

Phone No.  Fax No.  Email

Address  Postcode

## Worker's Employment Details

Full name of worker (Surname)  (First names)

Residential address  Postcode

Gender Male  Female  Date of birth  Marital Status - Married  Single  Defacto  Divorced

Occupation  Date first employed

Main tasks performed by worker

Is the worker a direct employee? YES  NO  If "NO", explain employment

Is the worker a member of the Employer's family? YES  NO  If "YES", do they reside together?

Is the worker employed by anyone else? YES  NO  If "YES", provide name and address

Is the worker a working director? YES  NO

**Compensation details**

Did the worker cease work because of the injury? YES  NO  If "YES", when?  Time  am/pm  
 If "NO", go to "Employer Declaration"

Has worker resumed work? YES  NO  If "YES", when?  Time  am/pm

What is the exact time lost: Weeks  Days  Hours  (To date of completion of form if work has not been resumed)

What are the normal working hours? (eg. 7.00 am to 3.30 pm Monday to Thursday; 7.00 am to 1 pm Friday)  
 Day  Day  Day  Day

No. of Hours worked per week

**Wage Information – (Complete only when claiming for lost time)**

**Weekly earnings for 13 week prior to incapacity**

Note: If agreed or market rate please confirm whether this is underpinned by an award classification or registered EBA

Is the worker employed under (please  tick the appropriate box)

Federal award  State award  Registered EBA  Unregistered EBA  Agreed or market rate

Is the worker employed Full time  Part time  Casual  Seasonal

Week ending dd/mm/yy	Ordinary hours	Base hourly rate \$	Overtime paid \$	Bonuses / Allowance (tools, site etc) \$	Over award payment \$	Annual leave \$	Sick leave \$	Public holidays \$	Rostered days off \$	Other days \$	Gross weekly earnings \$
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
<b>TOTAL GROSS EARNINGS</b>											<b>\$</b>

Note: If the worker is not employed under an award classification or Registered EBA, please provide details of the total gross earnings (excluding GST, leave loading) paid to the worker up to the length of service but not exceeding 12 months prior to the date of injury.

\$

The total number of weeks worked?

If not 52 weeks please confirm the dates worked  to

The base number of hours worked each week by the worker?

Total number of hours worked for the 52 weeks preceding the date of injury?

The base hourly rate paid to the worker? \$

**Injury Details (Please complete every particular)**

Date of injury  Which day of week?  Time of injury  am/pm

Date reported  Time reported  am/pm To whom was the accident reported?

If there was a delay in reporting the injury to you what reason was given for the delay?

Address and place where injury occurred

Names and addresses of witnesses (if any)

Details of previous similar injuries, if known

How did the injury occur and what was the worker doing at the time? (eg. slipped while walking down stairs)

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

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

**Safety Equipment (where applicable to the tasks which resulted in the injury)**

Had the worker been provided with safety equipment or clothing at the time of the accident eg. glasses, boots, harnesses? YES  NO

If "YES", was it being worn/used at the time of the accident? YES  NO  If "NO", why?

**Rehabilitation - (Complete only when the worker has not resumed work)**

Do you have any alternative duties the worker can perform until pre-injury fitness is achieved? YES  NO

Are you prepared to rehabilitate the worker under the guidance of a rehabilitation organisation? YES  NO

If "NO", state why

**Give details of other circumstances that may assist Zurich to assess the claim**

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

**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

**Employers, Please Note**

1. This Report of Injury must be forwarded to Zurich within 3 days of the Worker giving you a First Medical Certificate and Workers Claim Form together with those forms. Fines can be imposed for late notifications.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify Zurich when work is resumed.
3. **NO COMPENSATION PAYMENTS ARE TO BE MADE WITHOUT PRIOR APPROVAL FROM (ZURICH) AND ONLY AFTER RECEIPT OF A COVERING MEDICAL CERTIFICATE IN THE FORM PRESCRIBED UNDER THE ACT.**
4. Compensation will only be reimbursed at the rates advised by Zurich.
5. Medical accounts should be sent unpaid to Zurich.
6. Please telephone Zurich if you have difficulty completing this form or any other questions.

