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 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 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 ☐

WOR 00040-WA-9/04 - DJOE-644VWZ-2004

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												
											TOTAL GROSS EARNINGS	$

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.