

# WORKERS' COMPENSATION EMPLOYER'S REPORT



You must lodge this form with Allianz within **three working days** of being notified of an injured person's claim.

## 1 Employer Details

Legal Entity / Name

Trading Name

ABN Number

ITC % Entitlement

 %

Address

  
 Postcode:

Post Address

  
 Postcode:

Telephone

 ( )

Fax Number

 ( )

E-mail Address

Main Business or Industrial activity

Policy Number

Due Date

 / /

Risk Number

## 2 Claimant Details

Name

Address

  
 Postcode:

Home telephone

 ( )

Date of birth

 / /

Place of birth

If Claimant has difficulty understanding english, what is their preferred language?

Relationship to employer (if any)?

Occupation (including Industrial Award designation)

Marital status

No. Dependant children (under 16 years)

Is Spouse working?

No

Yes

How long has the Claimant been in your employment?

At the time of the occurrence was the Claimant working as a:

Direct Employee?

Working Director?

Contractor?

Employee of Contractor?

Sub-Contractor?

If Yes, give name and address of Contractor or Sub-Contractor?

Name

Address

  
 Postcode:

Does Claimant employ labour?

No

Yes

Other?

Describe the actual tasks carried out by the Claimant



## 5 Accident Description

What was the Claimant doing when the accident happened?

What caused the accident?

Were vehicles involved in the accident?

No  Yes

If Yes, complete claim form for Injury on the journey.

Was any other object, machinery, footwear, clothing or other item involved in the accident. If so, please provide details.

### Retain any such objects or items.

Describe the nature and extent of the injury.

Has the Claimant ever had a similar injury?

No  Yes

Give details.

Did the Claimant have any pre-existing condition, including any injury, disease or illness prior to the accident?

No  Yes

If Yes, give details.

Did any third parties cause or contribute to the accident?

No  Yes

If Yes, please provide contact details

If so, were there any contracts in existence between the employer and any such third parties?

No  Yes

## 6 Reporting

Date accident reported

Time

Name of person to whom the accident was reported.

Position

## 7 Other Benefits

Is the Claimant entitled to receive any allowance, benefit or compensation for this injury from any other source?

No  Yes

Given details.

## 8 Witnesses

Name

Name

## 9 Important

You must attach full details if:

- The Claimant violated any statutory (or other) regulation at the item of the accident.
- There was any misconduct by the Claimant (or any other party) that contributed to the accident.
- There are any special circumstances about which Allianz should be told.

## 10 Declaration

I declare the answers give on this form are true and correct.

Signature

Date

Print Name

## 11 Employer Notice

- \* Failure to lodge this form with Allianz within 3 working days of claim notification may result in you being penalised 3 days compensation.
- \* Attach employee's report and medical certificates to this form.
- \* **No compensation is to be paid until authority from Allianz has been obtained.**

Please return to either:

**Allianz Australia Insurance Limited**  
**PO Box K772**  
**City Delivery Centre WA 6842**

or

**Fax to: 08 9422 8497**

## BOX A

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Other \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						

\$  State base weekly or hourly award rate.

State award name and classification.

Please supply documentary proof.

## BOX B

\$  Total Gross Earnings

Dates employed if NOT full 52 weeks:

From

/  /  to

/  /

Please supply a detailed weekly summary of wages paid for this period.