WORKERS COMPENSATION
EMPLOYER'S CLAIM FORM

Under the Workers Compensation Act 1951 you must notify CGU Workers Compensation within 48 hours of being notified of the injury. If you have not notified CGU Workers Compensation of this injury, please contact our office immediately.

Before completing this form, please read the notes on the back. Print in block letters and mark with a tick where appropriate. Please submit via email workerscompclaims@iag.com.au

Policy number | ABN | Claim number | Department code

1. Employer details

Full name as per policy

Postal address

Postcode

Location address (specify number, street, suburb)

Postcode

Contact phone number | Email

Workplace size (number of employees in the ACT) | Business activity or profession

Name and location where worker is employed (branch, depot, etc.)

Location number | Employer contact | Employer contact phone number

Employer contact email

2. Worker's details

Given name(s) | Surname

Residential address

Postcode

Contact phone number

Date of birth D D / M M / Y Y | Sex M F

3. Injury Details

Where did the injury occur?

- ☐ At work
- ☐ During a break
- ☐ Vehicle accident while working
- ☐ Travelling to place of employment
- ☐ Travelling from place of employment
- ☐ Away from work during recess period
- ☐ At work, working away from normal workplace

Date of injury D D / M M / Y Y

Time of injury am/pm

Date of notice given to employer D D / M M / Y Y

Time of notice given to employer am/pm

Date reported to CGU Workers Compensation D D / M M / Y Y

Time reported to CGU Workers Compensation am/pm

If not reported to CGU Workers Compensation within 48 hours of notice of injury, employer is liable by operation of legislation for weekly compensation payments until injury was reported to CGU Workers Compensation.

To whom was the accident reported?

Place where injury occurred

Address where injury occurred

Postcode

Name and address of witnesses if any

Contact phone number

Postcode

Postcode

Postcode

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

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

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

Give details of other circumstances which would assist the insurer to assess the claim.
e.g. Do you query the validity of the claim? If so, why? If there is insufficient space, please attach a separate sheet.

In my opinion…

Details of previous injuries if known

4. Employment information

What is the average over the last 12 months of the pre-incapacity weekly earnings? (including overtime, only where overtime worked was within a regular and established pattern and the worker would have continued to work overtime had the worker not been injured)

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☐ Permanent ☐ Temporary ☐ Casual

☐ Temp Overseas Visa Worker ☐ Full time ☐ Part Time

Standard hours worked per week

Overtime hours worked per week

Number of days worked per week

Working pattern (e.g. 7:00 am to 3:30 pm Monday to Thursday, 7:00 am to 1:00 pm Friday)

☐ Direct employee ☐ Working Director ☐ Contractor ☐ Worker of Contractor

☐ Sub-Contractor ☐ Labour Hire Worker ☐ Apprentice/Trainee ☐ Other

Occupation or trade (e.g. cook, builders labourer)

Main tasks performed by worker

If other, please describe employment status

Date employed D D / M M / Y Y

Award or Agreement Title

Workers Classification number

Award Rate

5. Time lost particulars

Date worker ceased work D D / M M / Y Y Time am/pm

Has the worker resumed work No ☐ Yes ☐ Date resumed work D D / M M / Y Y Time am/pm

Exact time lost Days Shifts Hours

Date initial Certificate of Capacity medical certificate received by employer: D D / M M / Y Y

Please note a Certificate of Capacity medical certificate is required to substantiate any lost time from work.

6. Rehabilitation

Has the worker resumed work under the guidelines of a Rehabilitation Program? No ☐ Yes ☐

What Rehabilitation Program has been set down for an early return to work? Please give details.

Name of Employer Rehabilitation Coordinator

7. Employer's declaration

I, (print name and position)

declare that the details above are true and correct in every particular.

I agree that, by submitting this form, Any personal information I provide will be collected, stored, used and disclosed in accordance with CGU's Privacy Policy located at www.cgu.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.

Date D D / M M / Y Y

Signature of Employer or authorised person

Notes

Claims: The employer shall give notice to CGU Workers Compensation ("insurer") of any personal injury within 48 hours of becoming aware that the employee has sustained an injury. If the notice is given orally, the employer must notify the insurer in writing within 3 days of the oral notification.

Employer not to make admissions: The employer shall not, without written authority of the insurer, incur any expense or litigation, or make payment settlement or admission of liability in respect of any injury to or claim made by any worker.

If the worker has not resumed work at the time of lodgement of this claim, the employer must notify the insurer immediately the worker returns to work.

Payments will be made to the employer unless special arrangements are made.

Employers please note – this claim and any other documentation must be forwarded to CGU Workers Compensation within 7 days of receipt, in accordance with the Workers Compensation Act.

24 Brisbane Avenue Barton ACT 2600
PO Box 24113 Melbourne Vic 3001
Tel. (02) 6240 4790 Fax 1300 038 395

Insurer
Insurance Australia Limited
ABN 11 000 016 722 AFSL 227681
trading as CGU Workers Compensation