QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Canberra Branch
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ACT Employer's Report of Injury

Claim Number *(Office Use Only)*

Before completing this form, please read the notes on the back.

Employer's Details

Full Name (as per policy)

Policy Number

Telephone

Facsimile

ABN

Postal Address

Postcode

Site Address (specify number, street, suburb)

Postcode

Name and Location where Worker was employed (eg. depot, branch, etc)

Business Activity or Profession

Cost Centre Number

Name of Rehabilitation Coordinator

Worker's Details

Worker's Surname

Worker's Given Name(s)

Residential Address

Postcode

Date of Birth / /

Sex: Male ☐ Female ☐

Date Employed / /

Employed as: Permanent ☐ *or* Casual ☐ Full-time ☐ *or* Part-time ☐

Occupation

Hours worked per week

Main tasks performed by Worker

Is Worker a direct employee? Yes ☐ No ☐ - explain employment

Where time was lost, please complete questions on back of form. NB: please complete Declaration on the back of form.

Injury Details

Where did the injury occur? At work ☐ During a break at work ☐ Away from work during a recess ☐ Vehicle accident while working ☐ Travelling to or from a place of employment ☐

Date of Injury / /

Time of Injury am/pm

Date notice given / /

Time notice given am/pm

To whom was the accident reported

Address and place where injury occurred

Names and addresses of witnesses (if any)

Details of previous related 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 body parts were affected? (eg. upper arm, ankle)

Give details of other circumstances which would assist the Insurer to assess the claim (eg. Do you query the validity of the claim? If so, why?)

In my opinion

Time Lost Details

Date worker ceased work? / / Time worker ceased work? am/pm

Has worker resumed work? Yes ☐ No ☐ If "yes", date resumed work / / Time resumed work am/pm

Normal working hours: (eg. 7.00am to 3.30pm Monday to Thursday; 7.00am to 1.00pm Friday)

From am/pm to am/pm From am/pm to am/pm

Exact time lost to date: Days Shifts Hours Award hours worked per week Days worked per week Rostered days off

Award Details

Is the worker employed under an Award or Registered Industrial Agreement? Yes ☐ No ☐ If "Yes", complete (a)-(c) below

(a) The Federal or Territory Award or Registered Industrial Agreement under which the worker is employed

(b) Award classification name

(c) Award classification number grade or group

What is the worker's average weekly earnings, exactly as prescribed by the worker's classification name and number, grade or group in the Award or Registered Industrial Agreement mentioned above? Include shiftwork, overtime, penalty rates, over award payments or payments to cover expenses incurred.

Rate per week

What is the actual current rate per week paid to worker?

The worker is: An apprentice ☐ A trainee ☐ An indentured apprentice ☐

Which year of apprenticeship is the worker in? Ist Year ☐ 2nd Year ☐ 3rd Year ☐ 4th Year ☐

If the worker is employed as a part-time or casual employee, what is the average number of hours worked per week?

Rehabilitation

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

What Rehabilitation Plan has been set down for an early return to work? Give details

Name of Rehabilitation Coordinator

Employer Declaration

The Privacy legislation protects personal and sensitive information on this form that could reasonably identify you to another person. QBE will only use or disclose your personal information for purposes that would reasonably be expected during the claim process. We may need to share your information with our agents or service providers who may also be involved with your claim. This could include rehabilitation providers, medical practitioners, investigators, solicitors, other insurers, and national and overseas reinsurers. If we need to use the information for another purpose, we will ask you for your permission first. You will be provided with the opportunity to access your personal information (some restrictions and costs may apply). In respect of any complaint that you may have regarding your personal information, QBE will provide you with our dispute resolution procedures. If you would like any further information or if you have any concerns about how QBE is managing your personal information, please contact the Compliance Manager by email: compliance.manager@qbe.com or by telephone: (02) 9375 4656.

I *(print name, position)*

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

Signature of Employer or Authorised Person

Date / /

OFFICE USE ONLY

Approval:

From am/pm On / /

To am/pm On / /

Weekly Rate $

Other - Pay ☐ Employer ☐ Worker

Auth/Chq by / /

Initial Estimate $

F/U

Employers: Please Note

1. This notice of claim must be forwarded to QBE within 7 days after lodgement of claim by worker. This also applies to any documentation received in respect of claim.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify us immediately if the worker returns to work.
3. No compensation payments are to be made without our prior approval, and only after receipt of a covering medical certificate in the form prescribed under the Act.
4. Weekly benefits will be paid at the sick leave rate.
5. Payments will be made to you unless special arrangements are made.