QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Canberra Branch
Level 2, 33 Ainslie Avenue
Canberra City ACT 2601

PO Box 1008, Civic Square ACT 2608

Telephone (02) 6240 3434
Facsimile (02) 6249 8633

ACT Compensation Claim
Worker's Report of Injury

Claim Number _____ *(Office Use Only)*

To (Employer's full Name) _____

Whilst in your employ, I sustained the injury described below and elect to claim under the provisions of the ACT Workers Compensation Act.

Worker's Details

Worker's Surname _____ Worker's Given Name(s) _____

Residential Address _____ Postcode _____

Telephone _____ Date of Birth / / Sex: Male ☐ Female ☐

Occupation and Trade Qualifications _____

Married (including Defacto) ☐ Not Married ☐ Country of Birth _____

Language spoken at home _____ Is an interpreter required? Yes ☐ No ☐

Dependants

Is Spouse or Defacto Working? Yes ☐ No ☐

Full Name of Dependant	Relationship to Worker	Date of Birth	Full time Student				Residing at Home			
			Yes		No		Yes		No	
			Yes		No		Yes		No	
			Yes		No		Yes		No	

Other Current Employers

Do you have any other employment? Yes ☐ No ☐ If "Yes", please give details below

Full Name of Employer _____

Address _____ Postcode _____

Witnesses

Name	Address

Injury Details

Date of Injury / / Time of Injury _____ am/pm Date notice given / / Time notice given _____ am/pm

To whom was the accident reported _____

If you stopped work due to the injury:
Date stopped work / / Time stopped work _____ am/pm

Address and place where injury occurred (eg. machine shop) _____

What injury or injuries did you suffer (eg. fracture)? _____

Injury Details *(continued)*

How did the accident occur, and what were you doing at the time (eg. slipped while climbing a ladder)?

What parts of the body were affected (eg. upper arm, lower back)?

Was the body part normal before the accident? Yes ☐ No ☐

If "No", give details

Name of Treating Doctor (if applicable)

Name of Hospital (if applicable)

Is a medical certificate attached? Yes ☐ No ☐

Other Similar Injuries

Have you previously suffered any similar work-related injuries or conditions? Yes ☐ No ☐

If "Yes", give details of the nature of the injury/injuries

Journey Injury *(complete only if the injury occurred away from the employer's premises or while you were on a journey to or from work)*

The injury occurred while you were a: Pedestrian ☐ Driver ☐ Passenger ☐

Where were you travelling from?

Time you left: am/pm

Where were you travelling to?

Give details of owners of all vehicles and registration numbers

Name	Address	Registration Number

Which police station did you report it to?

Name of police officer (if known)

Date of Report / /

If this was a motor vehicle accident, has a Compulsory Third Party (CTP) claim been made? Yes ☐ No ☐

I give permission for any medical practitioner or authority to give information relevant to this claim to my employer's Insurer or ACT WorkCover. I agree that a photocopy of this authority shall be as valid as the original. I agree that while I am receiving weekly payments of compensation, I will notify my employer's Insure if:

- I start employment with some other person
- I start my own business
- There are changes in my employment affecting my earnings.

Signature

Date / /

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.

You must make this declaration before one of these:

A postmaster or person in charge of a Post Office, magistrate, justice of the peace, barrister or solicitor, school head teacher, member of the police force, medical practitioner, notary public, commissioner for declarations, minister of religion, member of the Legislative Assembly or the Parliament.

To the best of my knowledge and belief, all the information given in this form is true and correct.

Signature of Worker

Declared at

on the

of 20

Name and Title of Witness

To be completed by Employer

Date you received this claim / /

Signature of Employer

Date / /