Allianz ACT WORKERS COMPENSATION – EMPLOYERS CLAIM FORM

Before completing this form, please read the notes on the back. Print clearly and mark with a tick where appropriate.
If a worker is unlikely to resume their normal work for a continuous period of more than 7 days, legislation requires Allianz must be notified within 48 hours.
Phone **1300 360 595** for assistance with the notification process.

Policy Number.	Risk No.	Cost Centre No.	Incident Number.

1. Employer Details

Full Name as per Policy

Postal Address

Post Code

Contact Name

E-mail Address

Telephone Number

Fax Number

Location address of employer
(specify number, street, suburb)

Post Code

Workplace, name and location where worker is usually employed (ie, depot, branch, etc.)

Post Code

Main business activity or profession of employer

Business activity or profession of workplace where worker is usually employed

Rehabilitation or Return to Work Coordinator

Enter circumstances to assist Allianz assess the claim. Eg. Do you query the validity? If so, why? If space insufficient, please attach separate sheet.

2. Workers Employment Details

Surname of injured worker

First Name

Home Phone Number

Residential Address

Post code

Sex: Male ☐ Female ☐

Date of Birth

Date Employed

Full Time ☐ Part Time ☐

Permanent ☐ Casual ☐

Occupation

Is the worker:

An Apprentice ☐ Trainee ☐ Volunteer ☐

Main tasks performed by Worker

If not an employee, explain relationship

Normal Working hours eg.

7am to 3.30pm Monday to Thursday
7am to 1.00pm Friday

to days

to Days

Average weekly pre-incapacity hours calculated over the previous 12 months, or period of employment, if less than 12 months. Do not include overtime hours unless the overtime has been worked in a regular & established pattern.

Average weekly pre-incapacity earnings calculated over the previous 12 months, or period of employment if less than 12 months

3. Injury Details

Time of Injury

Date of Injury

Time reported to employer

Date reported to Employer

To whom was the accident reported?

Full address and place where injury occurred (accident location)

Postcode

Name & address of witness if any

Postcode

Details of Previous injuries, if known

Description of accident & location. Eg. slipped while walking downstairs

Describe the worker's injury or condition eg. laceration, dermatitis

Which parts of the body were affected? Eg. upper left arm

Hospital or Treating Doctor's name & phone number

4. Time Lost Details

Date Worker Ceased work

Time worker ceased work

Has the worker resumed work?

Yes ☐ No ☐

Date resumed work

Time resumed work

Exact time lost – in days & hours

Days Hours

EMPLOYERS PLEASE NOTE:

- **This form, together with the injured workers claim form, must be forwarded to Allianz CANBERRA –PO BOX 262 Canberra 2601 – within 7 days of receiving the workers claim form.**
- **The Act requires employers to report all injuries to their insurer within 48 hours of becoming aware of an injury. If this injury was not notified within 48 hours, the employer is liable for weekly compensation payments until Allianz is notified.**
- **A claim for weekly benefits will only be considered if accompanied by a medical certificate providing the doctors opinion on the relationship of the worker's injury to employment.**

I, (print name and position)

Declare that the details above are true & correct in every particular.

Signature of Employer or authorised person

Date

(N.B. Please contact your local Allianz Branch if you require any assistance in completing this form)

ACT WORKERS COMPENSATION – WORKERS CLAIM FORM

Policy No. _____ **Employer Name:** _____ **Incident Number** _____

Complete all questions fully and accurately, to ensure accurate decisions can be made about your claim

1. Worker's Particulars

Family Name | Male ☐ | Female ☐

Given (or first) Name (s)

Date of Birth

Telephone contact number(s)

Home

Work

Mobile

Residential Address

Postcode

Interpreter Required? Yes ☐ No ☐

Language

What is your country of birth?

Marital Status:

Dependant Details:

Name	Relationship	Date of Birth

2. Injury Details

How did the injury occur, and what were you doing when the injury happened? (Eg. slipped when climbing a ladder)

What part/s of your body is/are injured?

Was this part(s) of your body normal before the injury? Give details

What is the address where the injury happened? (if different to work address)

Postcode

Date of injury

Time of Injury

Did anyone see your Injury? Yes ☐ No ☐

If yes, names:

Name of person at your workplace you reported the injury to?

Name and position

Date reported

What's the name of your Nominated Treating Doctor?

Name

Telephone number

Other similar injuries

Have you previously suffered any similar injuries or conditions? Please give details (for examples, when this happened):

YOU MUST ALSO COMPLETE THE INFORMATION ON THE BACK OF THIS FORM BEFORE THE FORM IS SENT TO THE INSURER

3. Other Employment

Do you have a second job with another employer?

No ☐ Yes ☐

Name of second employer

Contact Name | Telephone Number

What is your average weekly earnings from this job?

$

What are the average weekly hours in this job?

4(i) Declaration

It is an offence to make false and misleading statements.

I, _____ certify that the Information I have provided is correct and I understand that whilst I am in receipt of weekly payments of compensation

I am obliged to immediately notify Allianz of:

(a) my commencing employment; or

(b) my commencing my own business; or

(c) any change in my employment that affects my earnings

I consent to Allianz and its appointed service providers collecting personal information about me and using it for the purpose of assessing and managing my workers compensation claim, including determining liability and whether my claim is true. I consent to my insurer disclosing my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purposes of assessing my claim. I also consent to Allianz disclosing personal information to the Workers Compensation Regulator which is authorised to use this information to fulfil regulatory functions under the workers compensation legislation.

Signature of Worker | Date

(ii) Authority

I, _____ hereby Authorise any medical practitioner or other authority to provide Allianz with any and all information regarding my medical and/or factual history in respect of the injury sustained on ____/____/____. A photocopy of this authority shall be as valid as the original.

Signature of Worker | Date

Please note: It is a requirement of the ACT Workers Compensation Act 1951 that injured workers authorise their treating doctor to provide relevant information to the insurer or employer for the purposes of injury management

5. What to do Next

1. Make sure you have completed the front of this form
2. Make sure you have signed the declaration and medical authority
3. Attach medical certificates and any other claim related information
4. If the injury occurred on a journey – complete an Injury of the Journey form
5. Give this form to your Employer

6. Date given to the employer:

Received by Employer

Name | Position

Signature | Date

7. Additional information (from either the Injured worker or the Employer)