employer's workers' compensation report of injury claim report

Lumley

Please reply to	Lumley Insurance
POSTAL ADDRESS	Locked Bag 1 Bassendean DC WA 6942
STREET ADDRESS	50 St Georges Tce Perth WA 6000
TELEPHONE	(08) 9220 8280
FACSIMILE	(08) 9378 2172

OFFICE USE ONLY

POLICY NUMBER	EXPIRY DATE	DATE C/F SENT
LOCATION	RISK	OFFICER
CLAIM NUMBER	EXCESS	ASSESSOR

NOTE
1. To avoid penalties that can be imposed on you under section 57A(2) of the Workers' Compensation and Injury Management Act for failure to make a claim within the time prescribed by that Act you must complete and return this report to Lumley Insurance within three (3) full working days of being notified of a claim.
2. All sections of this report must be completed and have attached any available medical certificates and other relevant documents.
3. A compensation payment is not to be made until Lumley Insurance give you authority to do so.

PRIVACY Personal information provided to us in this document and the information we collect from third parties in connection with your claim will only be used by us to deal with this claim and your future insurance arrangements and claims you might lodge with us. We will only pass the information to persons outside Wesfarmers General Insurance Limited if they are assisting us with the above matters or we are required by law to do so or you consent to our doing so. Please refer to the Privacy Statement on our website (www.lumley.com.au) for more information on how we handle your personal information.

DETAILS ABOUT YOU

LEGAL ENTITY NAME _____

TRADING NAME _____

POSTAL ADDRESS _____

_____ POSTCODE _____

STREET OR LOCATION ADDRESS _____
(If as postal address, write as above)

_____ POSTCODE _____

BUSINESS PH _____ MOBILE _____ FACSIMILE _____ EMAIL _____

MAIN BUSINESS OR INDUSTRY ACTIVITY _____ POLICY NUMBER _____

DETAILS ABOUT THE INJURED PERSON

FULL NAME IN BLOCK LETTERS _____ DATE OF BIRTH DD / MM / YYYY

POSTAL ADDRESS _____

_____ POSTCODE _____

STREET OR LOCATION ADDRESS _____
(If as postal address, write as above)

_____ POSTCODE _____

TELEPHONE PRIVATE _____ MOBILE _____

Has the injured person

(a) any family including extended family relationship to you? YES ☐ NO ☐ If Yes, give details _____

(b) been residing in the same dwelling as you? YES ☐ NO ☐

(c) a dependent spouse? YES ☐ NO ☐

(d) any dependent children? YES ☐ NO ☐

DETAILS OF WORKING RELATIONSHIP

OCCUPATION _____ DATE SERVICE COMMENCED WITH YOU _____

Is the service with you

(a) ☐ FULL TIME ☐ PART TIME ☐ CASUAL ☐ TEMPORARY ☐ PERMANENT

(b) ☐ DIRECT EMPLOY ☐ CONTRACTOR ☐ SUBCONTRACTOR

If the service with you is that of contractor or subcontractor, we will contact you for more information.

Does the injured person work for anyone else? YES ☐ NO ☐ If Yes, provide name _____

ADDRESS _____ CONTACT TELEPHONE _____

HOURS WORKED _____ RATE OF PAY _____

DETAILS OF WORKPLACE ARRANGEMENT AND REMUNERATION

Indicate which one of the following arrangements applies to the injured person:

(a) REGISTERED INDUSTRIAL AGREEMENT ☐

NAME OF AGREEMENT _____ STATE ☐ FEDERAL ☐

(b) UNREGISTERED INDUSTRIAL AGREEMENT ☐

(c) INDUSTRIAL AWARD ☐

NAME OF AWARD _____ STATE ☐ FEDERAL ☐

(d) ENTERPRISE BARGAINING AGREEMENT ☐

(e) ENTERPRISE ORDER ☐

(f) VERBAL AGREEMENT ☐

Show the total wages paid by you to the injured person during the 12 month period up to the date of the incident: $ _____

Show the number of weeks this is for if the number is less than 52 weeks: _____ weeks

(g) NONE OF (a) TO (f) ABOVE ☐

If you have indicated (a) or (c), show the Award hours per week for your industry _____

and the number of days worked by the injured person per week _____

and the normal hourly rate of pay _____

You must also now complete the wage information below so that we can calculate the correct rate for compensation payment.

Whichever of (a) – (g) you have indicated, we will advise you of the correct rate for compensation payment and if and when payments may proceed.

WAGE INFORMATION FOR THE 13 WEEKS IMMEDIATELY BEFORE THE INCIDENT

WEEK NO	WEEK ENDING	NUMBER HOURS WORKED		AWARD RATE PLUS ANY REGULAR ABOVE AWARD PAYMENT	OVERTIME (O/T)$	ALLOWANCES $	OTHER $	TOTAL $
		NORM	O/T					
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
TOTAL				$	$	$	$	$

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DETAILS OF INCIDENT

ALL QUESTIONS MUST BE ANSWERED

When did the incident occur? DATE _____ DAY _____ TIME _____ AM/PM

When did the injured person first report the incident to you? DATE _____ DAY _____ TIME _____ AM/PM

Did the injured person cease work? YES ☐ NO ☐

If Yes DATE _____ DAY _____ TIME _____ AM/PM

If No, is this claim for medical expenses only? YES ☐ NO ☐

Has the injured person returned to any employment? YES ☐ NO ☐

If Yes DATE _____ WITH WHOM _____

In what capacity? (For example, normal duties, light duties) _____

_____

Have you paid the injured person after the date of incident? YES ☐ NO ☐

If Yes, to what date have you paid? (See Note 3. on page 1.) DATE _____

Where did the incident happen? _____

Is this where the injured person usually works? YES ☐ NO ☐

If No, where is the usual place? _____

Was there a vehicle involved in the incident? YES ☐ NO ☐

(If there was more than one vehicle involved in the incident, provide the information requested here for each additional vehicle on a separate sheet of paper.)

If Yes MAKE OF VEHICLE _____

REGISTRATION NUMBER _____

REGISTERED OWNER _____

CONTACT TELEPHONE _____

DRIVER _____

CONTACT TELEPHONE _____

Describe what the injured person was doing leading up to the incident and how the incident happened. Please provide full details including the details of any premises, equipment, machinery or other object or animal involved. You must also tell us if there was any misconduct by the injured person or any other person which contributed to the incident.

_____

_____

_____

_____

At the time of the incident, was the injured person doing what they had been instructed to do and were they doing it in the way they had been instructed? YES ☐ NO ☐

If No, what were they doing which was different to their instructions? _____

Were there any witnesses to the incident? YES ☐ NO ☐

(If there was more than one witness provide the information requested here for each additional witness on a separate sheet of paper.)

If Yes NAME _____

ADDRESS _____

_____

CONTACT TELEPHONE _____

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DETAILS OF INJURIES

Describe the injury sustained by the injured person and advise each body part(s) injured.

Has the injured person commenced an Injury Management/Return to Work program? YES ☐ NO ☐

If No, why not _____

Did the injured person have any pre-existing injuries or disabilities that may have contributed to the incident or injury or that may extend the general period of recovery for injuries of this type? YES ☐ NO ☐ UNAWARE ☐

If Yes, give details _____

Provide details of the medical practitioner who first attended the injured person NAME _____

ADDRESS _____ CONTACT TELEPHONE _____

Do you have any reason to suspect that the injury suffered by the injured person is not a direct result of the incident that you have described or that the incident or injury is not directly work related? YES ☐ NO ☐

If Yes, give details _____

ENCLOSURES

Have you attached additional papers in answer to any questions in this report? YES ☐ NO ☐ If Yes, how many ____

You must enclose:

(a) Workers' Compensation Claim Form 2B completed by the injured person YES ☐ NO ☐

(b) First medical certificate YES ☐ NO ☐

(c) Other documents (such as accounts, prescriptions) YES ☐ NO ☐

If Yes, please specify

DECLARATION

I hereby declare the foregoing particulars to be true and correct in every respect and that no information has been exaggerated, omitted or withheld.

PRINT NAME _____ POSITION _____

SIGNATURE _____ DATE _____