Claim Form

Employer's Report of Injury

ZURICH

Privacy

- We need personal information to assess this claim. We will, where relevant, disclose personal information (other than sensitive information such as health information) to the employer (and any licensee, broker or agents appointed by the employer), the WA Workcover Authority, to other insurers, to our service providers (including loss adjusters and investigators) and our business partners for this purpose.
- Where relevant, to assess this claim we will also disclose personal information, including sensitive information such as health information, to the WA Workcover Authority, the employer (and any licensee, broker or agent appointed by your employer), medical practitioners, other health professionals, other insurers and reinsurers, legal representatives and other consultants. By signing this Claim Form, you consent to those organisations and other professionals collecting, and Zurich disclosing sensitive information for this purpose.
- A list of the type of service providers, business partners and consultants we commonly use is available on request, or on our website – go to www.zurich.com.au – and click on the Privacy link on our homepage.
- If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of this claim may be delayed or we may not accept the claim.
- We may also disclose personal information where we are required or permitted to do so by law.
- In most cases, on request, we will give you access to the personal information we hold about you.
- If you would like to find out more, you can contact us by telephone on 132 687, e-mail us at Privacy.Officer@zurich.com.au, or write to 'The Privacy Officer' at Zurich Australian Insurance Limited, PO Box 677, North Sydney, NSW 2059. Please provide details of your policy number/s and/or claim number where known.

Employers – please note

1. This Report of Injury form must be forwarded to Zurich within three days of the worker giving you a First Medical Certificate and Workers' Claim Form. All these forms should be sent to: Zurich Australian Insurance Limited, PO Box 422, West Perth WA 6872. Fines can be imposed for late notifications.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify Zurich when work is resumed.
3. No weekly compensation payments are to be made without prior approval from Zurich and only after receipt of a covering medical certificate in the form prescribed under the Workers' Compensation and Injury Management Act 1981 (WA) (the Act).
4. Weekly compensation will only be reimbursed at the rates advised by Zurich.
5. Medical accounts should be sent unpaid to Zurich.
6. Section 84AA – Employer to keep position available during workers' incapacity:

   Where a worker who has been incapacitated by injury attains partial or total capacity for work in the 12 months from the day the worker becomes entitled to receive weekly payments of compensation from the employer, the employer shall provide to the worker:

   (a) the position the worker held immediately before that day if it is reasonably practicable to provide that position to the worker; or

   (b) if the position is not available, or if the worker does not have the capacity to work in that position, a position

   (i) for which the worker is qualified; and

   (ii) that the worker is capable of performing.

   Most comparable in status and pay to the position mentioned in paragraph (a). (Penalty: $5000).
7. Section 84AB – Employer to notify worker and WorkCover WA of intention to dismiss worker:

   An employer must not dismiss a worker to whom Section 84AB(1) applies unless the employer has given to the worker and to WorkCover WA in accordance with subsection (2) a notice of intention to dismiss the worker, in the required form not less than 28 days before dismissal. (Penalty: $2000).
8. Section 155C requires an employer to establish a return to work program as soon as practicable if a worker's treating doctor advises the employer in writing that a program is necessary or the doctor signs a medical certificate that the worker has total or partial capacity to return to work.

   The employer must ensure that the establishment, content and implementation of a return to work program are in accordance with the code of practice. Under section 155D an employer may request in writing that their insurer assist in establishing a return to work program for a worker.
9. The legislative reforms will result in significant changes to an organisation's practices following a workplace injury.

   WorkCover WA has developed guidance notes to accompany the Code of Practice (Injury Management) that contains a template for an Injury Management System. The template illustrates that an Injury Management System can be a set of simple steps that provide for appropriate action to be taken by an employer when a workplace injury occurs.

   Employers who use the Injury Management System template would meet the requirements of Section 5 of the Code of Practice. For further information visit WorkCover WA's internet site at www.workcover.wa.gov.au or contact the WorkCover Infoline on 1300 794 744.
10. Please telephone Zurich if you have difficulty completing this form or any other questions.

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Employer details

Name of policy holder | Policy number

Trading name

What is your ABN | What is your Input Tax Credit (ITC) %

Postal address | Postcode

Location address (specify number, street, suburb)

Phone number | Fax number

Business (type of activity or profession)

How many people do you employ – (a) in total? | (b) in the worker's occupation?

Employer contact person dealing with workers' compensation claims

Name | Position

Phone number | Fax number

Email

Address | Postcode

Worker's employment details

Full name of worker – Surname | First names

Residential address | Postcode

Gender – Male ☐ Female ☐ Date of birth / / | Marital Status – Married ☐ Single ☐ Defacto ☐ Divorced ☐

Date first employed / / | Occupation

Main tasks performed by worker

Is the worker a direct employee? Yes ☐ No ☐ | If 'No', explain employment

Is the worker a member of the employer's family? Yes ☐ No ☐ | If 'Yes', do they reside with the employer? Yes ☐ No ☐

Is the worker employed by anyone else? Yes ☐ No ☐ | If 'Yes', provide name and address

Is the worker a working director? Yes ☐ No ☐ | If 'Yes', are they declared on the policy Yes ☐ No ☐

Injury details (please complete all particulars)

Date of injury / / | Which day of week | Time of injury am/pm

Date reported / / | Time reported am/pm

To whom was the incident reported?

If there was a delay in reporting the injury to you what reason was given for the delay?

Address and place where injury occurred

Names and addresses of witnesses

Details of previous similar injuries

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

Compensation details

Did the worker cease work because of the injury? Yes ☐ No ☐ If 'Yes', when? / / Time am/pm

If 'No', go to 'Injury Management / Rehabilitation' on page 4

Has worker resumed work? Yes ☐ No ☐ If 'Yes', when? / / Time am/pm

What is the exact time lost – Weeks Days Hours (To date of completion of form if work has not been resumed)

What are the normal working hours? (eg. 7.00 am to 3.30 pm Monday to Thursday: 7.00 am to 1 pm Friday)

Day Day Day Day

Number of hours worked per week

Wage information – (complete only when claiming for lost time)

Weekly earnings for 13 weeks prior to incapacity

Note: If agreed or market rate please confirm whether this was negotiated with reference to an award.

Is the worker employed under (please ✔ tick the appropriate box)

Federal award ☐ State award ☐ Registered EBA ☐ Unregistered EBA ☐ Agreed or market rate ☐

Is the worker employed – Full time ☐ Part time ☐ Casual ☐ Other ☐ Sub-contractor ☐ Contractor ☐

Award classification name

How many hours are specified in the award or registered enterprise bargaining agreement as a full-time week?

How many hours does the worker work per week? How many days are worked per week?

Are there any rostered days off? Yes ☐ No ☐ If 'Yes', which days?

What is the worker's weekly wage, exactly as prescribed by the relevant award, enterprise bargaining agreement, market or agreed rate? Excluding shiftwork, overtime, penalty rates, tool allowance, travel allowance, site allowance, over-award payments or payments to cover expenses incurred.

Base gross rate per week $ What is the actual current gross weekly rate paid to the worker $

	Week ending dd/mm/yy	Ordinary hours	Base hourly rate $	Overtime paid $	Bonuses/ Allowance (tools, site etc) $	Over award payment $	Annual leave $	Sick leave $	Public holidays $	Rostered days off $	Other days $	Gross weekly earnings $
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
											TOTAL GROSS EARNINGS	$

Note: If the worker is not employed under an award classification or registered enterprise bargaining agreement, please provide details of the total gross earnings (excluding GST, leave loading) paid to the worker up to the length of service but not exceeding 12 months prior to the date of injury.

Gross earnings $ The total number of weeks worked?

If not 52 weeks please confirm the dates worked / / to / / Number of weeks worked

Safety equipment where applicable to the tasks which resulted in the injury

Had the worker been provided with safety equipment or clothing at the time of the incident eg. glasses, boots, harnesses? Yes ☐ No ☐

If 'Yes', was it being worn / used at the time of the incident? Yes ☐ No ☐ If 'No', state why not?

Injury Management (please complete every particular in this section)

Do you have a written established injury management system, in accordance with the injury management code of practice and section 155B of the Act? Yes ☐ No ☐

If 'No', state why not?

Do you have a written established return to work program for injured workers, and are you able to implement a return to work program in accordance with the injury management code of practice and section 155C(1)(3) of the Act? Yes ☐ No ☐

If 'No', state why not?

Do you have any alternative duties the worker can perform until pre-injury fitness is achieved? Yes ☐ No ☐

Do you require further information to assist in establishing an injury management system or return to work program? Yes ☐ No ☐

Contact details of person responsible for day to day management of injury management systems within the workplace

Name Position

Phone number Fax number

Email

Address Postcode

Give details of other circumstances that may assist Zurich to assess the claim

(Include views as to the validity of the claim eg. misconduct, skylarking or pre-existing medical conditions contributing to the injury or incident).

Employer declaration

Commencement / Termination date Section 93O (Please complete if you have not clearly date stamped confirming when you first received the Workers' Claim Form or First Medical Certificate).

The date a completed and signed (Form 2B) Worker's Claim Form was first received? / /

The date a First Medical Certificate supporting the claim lodged was first received? / /

I (print name and position)

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

Signature of employer or authorised person Date

✗ / /