Employer's Report of Injury



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

- 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.

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 worker	rs' compensa	ation 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 Surgic Surgic Senacto	Divorced
Main tasks performed by worker		Occupation	
Is the worker a direct employee? Yes	No 🗍	If 'No', explain employment	
is the worker a direct employee?	100	п по , ехріані етіріоўпіені	
Is the worker a member of the employer's family? Yes	No No	If 'Yes', do they reside with the employer?	Yes No
Is the worker employed by anyone else? Yes	No No	If 'Yes', provide name and address	
		,,,	
Is the worker a working director?	No No	If 'Yes', are they declared on the policy	Yes No
-			
Injury details (please complete all particulars)		T	
Date of injury / / Which day		Time of injury	am/pm
Date reported / / Time report	iea	am/pm	
To whom was the incident reported?		r for the delay?	
lf there was a delay in reporting the injury to you what re	eason was give	n for the delay?	
Address and place where injury occurred			
realess 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	g at tne time? ((eg. siipped wniie walking down stairs)	
Describe the worker's injury or condition (eg. laceration,	dermatitis)		
Which parts of the body were affected? (eg. upper left a)	
parts or the sody were directed: (eg. upper left a	, ngin ankle		

Did the worker rease work because of the injury? Yes No If Yes', when? / / Time anripm (TWo, go to 'linjury Management' / Rehabilitation' on page 4 Has worker examed work? Yes No If Yes', when? / / Imme anripm (What is the exact time lost – Weels 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 Trunsday, 7.00 am to 1 pm Irriday) Day Da	Compensation	details										
Has worker resumed work? Yes Days Hours (to date of completion of form if work has not been resumed) 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 thrusday; 7.00 am to 1 pm Friday) Day Day Day Day Day Day Day	Did the worker c	ease work be	ecause of t	the injury?	Yes N	10 <u> </u>	If 'Yes	, when?	/	/	Time	am/pm
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Safety equipment where applicable to the tasks which res	ulted 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?		•••••••••••••••••••••••••••••••••••••••
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Initian Management (allows a constitutions)	hts 4!\		
Injury Management (please complete every particular in t			
Do you have a written established injury management system, in accord and section 155B of the Act?	ance with the injury management code of practice	Yes	No
If 'No', state why not?			
			•••••••••••••••••••••••••••••••••••••••
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Do you have a written established return to work program for injured w		Vos 🗌	No 🗌
work program in accordance with the injury management code of pract If 'No', state why not?	ice and section 155C(1)(3) of the Act?	Yes	No
ii No , state why not:			
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Do you have any alternative duties the worker can perform until pre-inju	ury fitness is achieved?	Yes	No
Do you require further information to assist in establishing an injury man	nagement system or return to work program?	Yes	No
Contact details of person responsible for day to day manag	coment of injury management systems within	n the wer	knlaca
		n the wor	кріасе
Name	Position		
Phone number	Fax number		
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