Allianz

Worker's Claim Form

Policy No _____ Incident No _____

Employer Name _____

Complete all questions fully and accurately to ensure appropriate decisions can be made about your claim.
Please ensure you complete **ALL pages of this claim form** before you submit it to your employer.

Worker's Details

Full name of worker _____

Male Female

Address _____

_____ State _____ Postcode _____

Telephone Work _____ Home _____ Mobile _____

Email _____

Date of birth _____

Country of birth _____

Language _____

Is an interpreter required? Yes No

Are you temporarily in Australia on a visa? Yes No

If Yes, expiry date of visa _____ Visa type _____

Marital status _____

Dependent details

Name	Relationship	Date of Birth

Injury Details

How did the injury occur? _____

_____

What were you doing when the injury happened? (e.g. slipped when climbing a ladder) _____

_____

Part(s) of body injured _____

_____

Was this part(s) of your body fully functional before the injury? Yes No

If No, please give details _____

_____

Address where the injury happened (if different to work address) _____

_____State _____ Postcode _____

Date of injury _____ Time _____ AM / PM

Did anyone see your injury occur? Yes No

If Yes, please provide their name(s) _____

_____

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

Name _____

Job title _____

Date reported _____

What is the name of your Nominated Treating Doctor?

Name _____

Telephone _____

Other similar injuries

Have you previously suffered any similar injuries or conditions? Yes No

If Yes, please give details (e.g. when this happened) _____

_____

_____

Other Employment

Do you have a second job with another employer? Yes No

Name of second employer _____

Contact name _____

Telephone _____

Average weekly earnings from this job $_____

Average weekly hours from this job _____

Declaration

It is an offence to make false and misleading statements.

I, _____ confirm that the information I have provided is correct and I understand that whilst I am in receipt of weekly payments of compensation I am obligated 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 (including sensitive information) about me including from third parties who assist Allianz in assessing my claim, including my employer.

I acknowledge that Allianz may use my personal information for the purpose of assessing, processing, settling and managing my workers compensation claim, verifying any evidence I may submit in support of the claim, resolving any claim disputes and managing my Return to Work program.

I also acknowledge that Allianz may disclose my personal information, inclusive of sensitive information, to my employer, other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purposes above. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to Allianz disclosing my personal details to WorkSafe ACT which is authorised to use this information to fulfil its functions and obligations under the workers compensation legislation.

Signature of Worker Date _____

Collection of this information is required by the ACT Workers Compensation Act 1951. If you do not provide any part or all of this information, your claim may not be accepted or processed.

For information about how you may access and request correction of your personal information, or complain about a breach of the Australian Privacy Principles, please see our privacy policy available at http://www.allianz.com.au/about-us/privacy.

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.

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. If the injury occurred on a journey – complete an 'Injury on the Journey' form.
4. Attach medical certificates and any other claim related information. **Please note:** A claim for weekly benefits will only be considered if accompanied by a medical certificate providing the doctor's opinion as to the cause of the injury, the relationship of the injury to employment, the diagnosis and recommended treatment.
5. Give this form to your employer.

Date this form was provided to Employer _____

Received by Employer

Name _____

Job title _____

Signature Date _____

Additional Information (from either the Worker or the Employer)