icare
Insurance for NSW

Allianz

Recurrence of Injury Form.

Complete all questions fully and accurately. Print in block letters and tick where appropriate. If claim is a result of a journey, please also complete Injury on the Journey Claim Form.

Employer Name | Claim Number | Policy Number

1. Worker's particulars

Family Name | Male ☐ | Female ☐

Given (or first) Name(s)

Date of Birth (/ /) | Telephone contact number

Residential Address

Postcode

2. Injury details

Date of recurrence of injury (/ /) | Time of recurrence of injury (am/pm)

How did the recurrence of injury occur?

What were you doing when the recurrence of injury occurred?

Describe your injury or condition (e.g. laceration, sprain)

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

What is the address where the recurrence of injury occurred? (If different to work address)

Postcode

Date Ceased Work (/ /) | Date Resumed Work (/ /)

What is your current work fitness?

☐ Pre-injury duties ☐ Suitable duties ☐ Unfit for work

Did anyone see your accident? ☐ Yes ☐ No

If yes, names:

When you sustained the recurrence of injury were you employed by the same employer as when you sustained your original injury?

☐ Yes ☐ No

If no, please provide new employer details

Postcode

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

Name | Date reported (/ /)

Position | Time reported (am/pm)

What is the name of your Nominated Treating Doctor?

Name | Telephone Number

Address

3. Original Injury details

Date of original injury (/ /)

How did the original injury occur?

Describe the nature of the original injury/condition (eg. sprain, laceration)

What part/s of your body were injured?

Did you fully recover from your original injury?

☐ Yes ☐ No

Date Ceased Work (/ /) | Date Resumed Work (/ /)

Did you return to pre-injury duties? ☐ Yes ☐ No

On the next page, please complete as many of the details that you know. This will help the insurance company process your claim as quickly as possible. If you do not know all the answers ask your employer or supervisor to complete this part of the form.

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

Please return completed forms to Allianz by post or by fax to: Allianz Australia, GPO Box 4056, Sydney NSW 2001 Fax: (02) 9266 7362. Tel: 1300 788 946

Allianz Australia Insurance Limited ABN 15 000 122 850 (Allianz) As agent of NSW Self Insurance Corporation, known as Insurance for NSW ABN 97 369 689 650.

WCNSW0062TMF 12/06

4. Work details

(a) The job where you were injured

What is your:

Occupation

Workplace Industry

Employed as:

☐ Full Time ☐ Part Time ☐ Casual ☐ Permanent

Normal Workplace Address

Postcode

What is your gross pay weekly?

$

How many total hours do you work per week?
Eg. 7am to 4pm Mon-Fri

What are your normal working hours? HH:MM

Are you employed under an award? ☐ Yes ☐ No

If yes, please state name of award

Employee Number

Cost Centre Number

(b) Other Jobs

Do you have a second job with another employer?

☐ Yes ☐ No

Name of second employer

Contact Name

Telephone Number

What is your gross pay weekly in this job?

$

How many total hours do you work per week in this job? HH:MM

5. Your employer's details

Main Business Address

Postcode

Australian Business Number (ABN)

Contact Person for Injury
Name

Address

Postcode

Phone Number

6. What to do next

1. Make sure you have completed both sides of this form.
2. Sign the declaration below.
3. Attach any WorkCover medical certificates to this form.
4. Attach a copy of your pay slips.
5. Give this form to your employer or insurer.

Date given to employer / /

Date given to insurer / /

Received by Employer

Name and position

Date received / /

Additional Information (from either the injured worker or the employer):

7. Injured worker's declaration

I certify that the information I have provided is correct.
I consent to the insurer and its appointed service providers collecting personal and health information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true. I consent to the insurer disclosing my personal and health information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purposes of assessing and managing my claim, facilitating any injury management and return to work programmes. I consent to the insurer disclosing my personal and health information to my employer for the purposes of injury management. I also consent to the insurer disclosing my personal details to the WorkCover Authority, which is authorised to use this information to fulfill its functions under the NSW workers compensation legislation. I understand that if any information I have given is untrue, that my claim may be denied and that I may be prosecuted.

Note: a photocopy of this authority shall be as valid as original.

Signature of injured worker

Date / /

Please attach any additional information directly to this form