

Underwritten
Workers
Compensation

Incident Lodgement

ACT

Employer Details

Employer Name		ABN	Policy Number
Business Address			
Suburb	State	Post Code	Country (if not Australia)
Postal Address			
Suburb	State	Post Code	Country (if not Australia)
Employer Contact Person			
Business Phone	Business Fax	Business Email	

Injured Worker Details

Surname		Given Name(s)	
Home Address			
Suburb	State	Post Code	Country (if not Australia)
Home Phone	Mobile	Email	
Occupation	Date of Birth	Gender	

Injury Details

Date of Injury		Time of Injury	
Address Where the Injury Occurred			
Suburb	State	Post Code	Country (if not Australia)

Injury Details Continued	
Injury Sustained	
Body Location	
Cause of Injury	

Treating Doctor			
Medical Practice		Treating GP	
Address of Medical Practice			
Suburb	State	Post Code	Country (if not Australia)
Business Phone	Business Fax	Business Email	

First Aid Treatment
First Aid Provided?
(If Yes, please provide details below)
Details (Including Name of Providers and details of treatment)

Witness Details		
Where there any Witnesses to the Injury?		
(If Yes, please provide details below)		
Name of Witness	Position	
Address		
Business Phone	Business Fax	Business Email

Employer Certification		
Representative's Signature	Name	Date

PLEASE NOTE:

If the injury is not reported within 48 hours, of the employer becoming aware of the injury, there are financial penalties.

Please forward completed documentation to Allianz:

- Contacting Allianz on 1300 130 664
- Emailing Allianz at actwc.newclaims@allianz.com.au