

WORKERS' COMPENSATION EMPLOYER'S REPORT



You must lodge this form with Allianz within five working days of being notified of an injured person's claim.

1 Employer Details

Legal Entity / Name

Trading Name

ABN Number

ITC % Entitlement

 %

Address

 Postcode:

Postal Address

 Postcode:

Telephone

Fax Number

E-mail Address

Main Business or Industrial Activity

Policy Number

Due Date

Risk Number

2 Claimant Details

Name

Physical Address

 Postcode:

Email Address

Home Telephone

Mobile Number

Place Of Birth

Date Of Birth

If Claimant has difficulty understanding English, what is their preferred language?

Relationship to Employer (if any)?

Occupation (including Industrial Award designation).

Marital Status

No. Dependant Children (under 16 years)

Is Spouse working?

No

Yes

How long has the Claimant been in your employment?

Is the Claimant on a Visa? No Yes

If Yes, what type of Visa is the Claimant on?

e.g. 457 working holiday

When does the Visa expire?

At the time of the occurrence was the Claimant working as a:

Direct Employee?

Working Director?

Contractor?

Employee of Contractor?

Sub-Contractor?

If Yes, give name and address of Contractor or Sub-Contractor?

Name

Address

 Postcode:

Does Claimant employ labour?

No

Yes

Other?

Describe the actual tasks carried out by the Claimant.

Did the Claimant participate in any non-work related activities, which may have contributed to the condition?

No Yes

If Yes, give details.

Has the Claimant completed an Application for Employment Form?

No Yes

Has the Claimant undergone a pre-employment medical examination?

No Yes

Describe any other factors, which may have contributed to the occurrence.

3 Accident Details

Date of Accident

Time

Location

This claim is for Medical Expenses No Yes
Weekly Payments No Yes

If Yes, complete Section 4.

Time Claimant commenced work on the day of the accident?

Time Claimant usually commenced work?

Time Claimant usually finished work?

am/pm

Date Claimant ceased work as a result of the accident?

Has the Claimant returned to work?

No Anticipated return date

Yes Date returned

Was the Claimant injured as a result of their employment?

No Yes

Did the Claimant consume any alcohol or non-prescribed drugs in the 12 hours preceding the accident?

No Yes

If Yes, give details.

4 Wage Details

Number of days in working week.

Number of hours worked per day.

Is the Claimant: Full Time? Part Time?
Permanent? Temporary?
Casual?

If part-time or casual, nominate the regular number of hours worked on each day.

S	M	T	W	T	F	S

If the claimant is paid pursuant to an Industrial Award, Workplace Agreement or Agreed Contract the following wage information is required to calculate the rate of pay.

* Please complete Section A on the last page.

First 13 Weeks

Provide details for the 13 weeks wages paid prior to date of incapacity.

* Do not include any time lost from work due to sick or annual leave or any other non-work related matter.

Week 14 and Ongoing

For the purpose of making weekly payments under Workers' Compensation and Injury Management Act 1981 (as amended) for the weeks subsequent to the first 13 weeks the claimant is entitled to the equivalent of the Industrial Award/EBA plus any regular above award payment and any allowance paid on a regular basis excluding overtime, allowances and bonuses.

If the claimant is paid pursuant to an Agreement including a Workplace Agreement the following wage information is required to calculate the rate of pay.

* Please complete Section B on the last page.

The Total Gross Earnings for the 52 weeks prior to the date of injury.

* If the claimant has not been employed for the full 52 weeks please specify the full period of employment.

Please note that any wages paid on the date of injury should not be included.

5 Accident Description

What was the Claimant doing when the accident happened?

What caused the accident?

Were vehicles involved in the accident?

No Yes

If Yes, complete claim form for Injury on the Journey.

Was any other object, machinery, footwear, clothing or other item involved in the accident? If so, please provide details.

Retain any such objects or items.

Describe the nature and extent of the injury.

Has the Claimant ever had a similar injury?

No Yes

If Yes, give details.

Did the Claimant have any pre-existing condition, including any injury, disease or illness prior to the accident?

No Yes

If Yes, give details.

Did any third parties cause or contribute to the accident?

No Yes

If Yes, please provide contact details.

If so, were there any contracts in existence between the employer and any such third parties?

No Yes

6 Reporting

Date Accident Reported

Time

Name of person to whom the accident was reported.

Position

Date claim documents were given to the Employer by the Worker.

7 Other Benefits

Is the Claimant entitled to receive any allowance, benefit or compensation for this injury from any other source?

No Yes

If Yes, give details.

8 Witnesses

Name

Name

9 Important

You must attach full details if:

- The claimant violated any statutory (or other) regulation at the time of the accident.
- There was any misconduct by the claimant (or any other party) that contributed to the accident.
- There are any special circumstances about which Allianz should be told.

10 Declaration

I declare the answers give on this form are true and correct.

Signature

Date

Print Name

11 Employer Notice

- * Failure to lodge this form with Allianz within 5 working days of claim notification may result in you being penalised 3 days compensation.
- * Attach employee's report and medical certificates to this form.
- * Do not commence paying compensation until advised to do so by Allianz.

Please return to:

Allianz Australia Insurance Limited
GPO Box K772
Perth WA 6842

or

Email: WAWC.NewClaims@allianz.com.au

BOX A

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Other \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						

\$ State base weekly or hourly award rate.

State award name and classification.

Please supply documentary proof.

BOX B

\$ Total Gross Earnings

Dates employed if NOT full 52 weeks:

From

to

Please supply a detailed weekly summary of wages paid for this period.

RATE OF PAY CALCULATION (SHEET 1)

Schedule 1 Clause 11

CLAIM NUMBER: _____
 EMPLOYER: _____
 WORKER: _____
 DATE OF INJURY: _____

AMOUNT A – WORKER EMPLOYED PURSUANT to an Industrial Award, Workplace Agreement or Agreed Contract.

*COPY OF EMPLOYMENT CONTRACT ATTACHED YES NO

PART 1 – Clause 11(2) - Calculation for the First 13 Weeks

Capped at the maximum weekly amount

= The average of the overtime, over award, service payments, bonus or allowances for the 13 weeks prior to the date of incapacity + the award rate

OR

If the worker was employed for less than 13 weeks (or any weeks which included time lost due to sick or annual leave) then averaged over that lesser period.

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Regular Over Award or Service Payments \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						

= \$ _____ Gross Per Week

PART 2 – Clause 11(3)(b) – Calculation for Week 14 and Ongoing

Capped at the maximum weekly amount

The rate of weekly earnings under the relevant Award or Agreement, plus any over award or service payments made on a regular basis plus any allowance paid on a regular basis as part of the worker’s earnings and relating to the number or pattern of hours worked, but EXCLUDING overtime, other allowances and bonuses, up to the maximum weekly capped amount.

= \$ _____ Gross Per Week

RATE OF PAY CALCULATION (SHEET 2)

Schedule 1 Clause 11

CLAIM NUMBER: _____
EMPLOYER: _____
WORKER: _____
DATE OF INJURY: _____

AMOUNT B – SUB CONTRACTOR OR WORKER EMPLOYED on a rate per hour, or as per contract (written or verbal) with the insured or any agreement not certified with the Industrial Relations Commission.

NB: This does not include casual or seasonal workers under Clause 14.

*COPY OF SUB CONTRACTOR LETTER OR CONTRACT ATTACHED YES NO

*DETAILS OF VERBAL AGREEMENT ARE:

*PLEASE ATTACH A COPY OF 52 weeks Gross Earnings (inclusive of overtime and any bonus or allowances) PRIOR TO THE DATE OF INJURY.

PART 1 – Clause 11(2) - Calculation for the First 13 Weeks

Capped at the maximum weekly amount

Divide the gross amount by 52 weeks.

OR

If the worker was in more than one employment at the end of that period, the sum of the average weekly gross earnings in each employment, divided by the lesser period.

OR

If the worker has been in an employment for a period of less than one year, the worker's average weekly earnings in that employment is to be determined over the lesser period.

= \$ _____ Gross Per Week

PART 2 – Clause 11(4)(b) – Calculation for Week 14 and Ongoing

Capped at the maximum weekly amount

= 85% of **Amount B**

= \$ _____ Gross Per Week