WORKERS' COMPENSATION EMPLOYER'S REPORT

Allianz

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 am/pm

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? am/pm

Time Claimant usually commenced work? am/pm

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

The worker's average weekly rate of earnings is calculated based on earnings for the period 1 year from the day before the date of injury or, if the worker has been employed for less than 1 year, earnings between their commencement and the day before the date of injury.

If the worker has taken leave without pay (time off work without pay on leave that is authorized or consented to by an employer for a period the worker would otherwise be required to work), the part of the period for which the worker was on leave must be excluded in making the calculation.

If the worker did not hold a position with the employer liable to pay income compensation on the date of injury, the date of injury is taken to be the date the worker last held a position with the employer.

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 am/pm

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
PO Box K772
Perth WA 6842

Fax: 1300 662 439 or (08) 9422 8650

Email: WAWC.Claims@allianz.com.au

RATE OF PAY CALCULATION

CLAIM NUMBER: _____

EMPLOYER: _____

WORKER: _____

DATE OF INJURY: _____

Dates employed if NOT full 52 weeks

From	/ /	to	/ /

Dates of leave taken without pay that was authorized or consented to by the employer that the worker would otherwise be required to work:

From	/ /	to	/ /
From	/ /	to	/ /
From	/ /	to	/ /
From	/ /	to	/ /

$	**Total Gross Earnings**

In accordance with Sections 54 and 55 of the *Workers Compensation and Injury Management Act 2023:*

- The worker's pre-injury rate of income is an average of the worker's earnings in the period of 1 year prior to the date of injury, less periods that the worker was on authorized unpaid leave.
- The worker is to be paid income compensation at the pre-injury rate of income for the first 26 weeks in which income compensation is payable.
- To the extent that income compensation is payable after the first 26 weeks, the worker is to be paid income compensation at 85% of the pre-injury rate of income.

The rate of income compensation is not to exceed the maximum weekly rate or be less than the minimum amount under the *Minimum Conditions of Employment Act 1993* or the base award rate and the regular additional earnings component including overtime and allowances.