Allianz

Workers' Compensation Employer's Report

Policy Details						
Legal Entity / Name:						
Trading Name:						
ABN:						
ITC Entitlement	%					
Policy Number:						
Cost Centre:						
Main Business Activity:						

Employer Details	
Employer Contact:	
Physical Address:	
Postal Address (if different from above):	
Phone Number:	
Email Address:	
Preferred Method of Contact:	

Worker Details	
Full Name:	
Date of Birth:	
Phone Number:	
Email Address:	
Physical Address:	
Postal Address (if different from above):	
Marital Status:	
Dependents (under 16 years):	
Occupation:	
Employment Status:	
Describe Actual Worker Tasks:	
Date of Employment:	
Is the Worker on a Visa?	
Visa Type (if applicable):	
Visa Expiry Date (if applicable):	
If Contractor or Sub-Contractor, please provide:	
Business Name:	
Business ABN:	
Business Address:	
Does the Worker employ labour?	
Please supply any relevant contracts, employment letters, pre-employment medicals, etc. when returning this form.	

Accident Details	
Date of Accident:	
Time of Accident:	:
Injury Diagnosis:	
Description of Accident:	
What action caused the accident?	
Were vehicles involved in the accident?	*If yes, Allianz will forward a Journey Claim Form for completion.*
Was any object / machine / substance involved? If so, please provide details	

Accident Location (include address):	
Name of person and position to whom accident was reported:	
Witness Names (if applicable):	
Witness Contact Information (if applicable):	
Time worker commenced work on the date of the accident?	:
Time worker ceased work because of the accident?	:
Time worker usually finished work?	:
Has the Worker Returned to Work?	
Was the worker injured because of their employment?	
Did the worker consume any alcohol, drugs, or non-prescribed medications in the 12 hours prior to the accident?	
Did the worker participate in any non-work-related activities, which may have contributed to the condition?	
Did any third parties cause or contribute to the accident?	
Is the worker entitled to receive any allowance, benefit, or compensation for this injury from any other source?	
Do you have any concerns with this claim?	
Any other information:	

Claim Details	
Date Accident Reported:	
Time Accident Reported:	:
Date Claim Documents Provided to Employer:	
Claim Type:	
If Other claim type, please specify:	
Employer Signature:	
Date:	
Print Name:	

Employer Notice

- *Attach Employee's Report Form and any Certificate of Capacities to this form.*
- ***Do not commence paying compensation until advised to do so by Allianz.***

Please return completed forms to:

Email: WAWC.Newclaims@allianz.com.au

-or-

Allianz Australia Insurance Limited
PO Box K772, Perth WA 6842

Wage Details
Please only complete these sections if the claim includes an income compensation component.
If the injured worker has been certified incapacitated because of the alleged work-related injury, please provide: - Title of the Award and/or the registered employment agreement the worker is employed under; and - 52 weeks of payslips prior to the Date of Accident so that a calculation of a pre-injury weekly rate of income can be undertaken. Title of Award and/or Registered Employment Agreement: _____ Failure to provide this information could lead to a delay in the payment of income compensation arising from the alleged injury which could see a fine of $5,000.00 applied for each week of compensation not paid.