Employer's Report of Injury Western Australia

This form is to be fully completed by the Employer and should be accompanied with the injured Worker's claim form and first medical certificate. Please ensure all of these documents are forwarded to GIO within 5 business days of receiving notification of the worker's claim, using the email address wcclaimswa@gio.com.au

Please do not commence making any payments until authorised by GIO.

1. Employer's Details

Policy number: Cost Centre:

Business Name:

Trading Name:

Employer's ABN ACN:

Postal address:

Suburb State Postcode

Address where Injured Person usually works:

Suburb State Postcode

Nature of Business:

Contact Person: Telephone:

Email Address:

2. Injured Person's Details

Given Name: Surname:

Address:

Suburb State Postcode

Date of Birth: / / Telephone:

Email Address:

Relationship (if any) to the employer:

3. Employment Details

Date Employed: / / Occupation at time of injury:

Employment Status

Direct Employee: Yes ☐ No ☐ If Yes, please select type of Worker: Full-Time ☐ Part-Time ☐ Casual ☐

On a Visa ☐ Visa Type Visa Expiry Date / /

Is the injured person a Subcontractor/Contractor Yes ☐ No ☐ Working Director: Yes ☐ No ☐

Normal work days: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Normal hours worked per day Normal hours worked per week

Start time Finish time Is this the same every day Yes ☐ No ☐

If the hours and days worked vary i.e. FIFO please provide details:

Is the injured person employed under: Industrial Award ☐ Non-Industrial Award ☐

What is the name of the award/agreement:

4. Injury Details

Date of Injury: / / Time of Injury: am/pm

Date Injury Reported: / / Name of person to whom injury was reported to:

Date Injured person's claim form received: / / Date first medical cert received: / /

Location address where injury occurred:

Suburb State Postcode

Give details of how the injury occurred:

Was the Injured Person performing their normal work when the injury occurred: Yes ☐ No ☐

Was the injury caused by a person(s) not employed by your business: Yes ☐ No ☐

What is the nature of the injury eg. laceration to right thumb:

Name of Witness 1: Telephone:

Name of Witness 2: Telephone:

Name of Witness 3: Telephone:

Do you support the claim. Yes ☐ No ☐

If no, please outline your concerns regarding the validity of the claim:

5. Work Status

Has the injured person ceased work:

Yes ☐ No ☐ If Yes – date ceased / / Time am/pm

If yes, has the injured person returned to work:

Yes ☐ No ☐ If Yes – date returned / / Time am/pm

If yes, what duties are the injured person performing:

Alternate Duties: Yes ☐ No ☐ Pre-injury hours and duties: Yes ☐ No ☐

If work has not been resumed what is the expected date of return to work: / /

If Injured Person has return to work on alternate duties has a return to work program been implemented. If yes, please attach a copy:

Yes ☐ No ☐

If no, would you like GIO to appoint a Workplace Rehabilitation provider: Yes ☐ No ☐

Do you have a preferred Workplace Rehabilitation provider. If so, who:

6. Injured Person's Earnings

If the injured person has been medically certified unfit or has a restricted capacity for work we require details of their past earnings to enable us to calculate the weekly rates of pay.

We require a copy of the wage history (in the form of pay slips) for 52 weeks up to the day before the date of injury.

If the injured person has been employed with your business for less than 52 weeks, we only require wage history/pay slips for this lesser period.

The wage history must only relate to the occupation that the injured person was employed, at the time of the injury.

Do not commence payment of weekly income compensation payments until we advise you of the weekly rate applicable to the claim.

7. Declaration

Note: This form is to be signed by a person (other than the injured person) authorised by the employer

I declare that the information contained in this form are true and correct.

Employer's Signature

Date

/ /

Name of signee:

Position of signee:

8. Checklist

Workers Claim Form *	Yes ☐	No ☐
First Medical Certificate *	Yes ☐	No ☐
Incident notification report	Yes ☐	No ☐
Witness Statements	Yes ☐	No ☐
Wages history/pay slips	Yes ☐	No ☐
Return to Work Program	Yes ☐	No ☐
Medical Reports including scans	Yes ☐	No ☐

(*) Required for claim lodgement

9. Electronic Funds Transfer Authority

The following authorisation allows GIO to credit the below nominated bank account in respect to payments relating to this claim.

This authority remains active for the duration of the claim unless revoked in writing.

Please provide the following information:

Name of Bank:

Account Name:

Account Number:

BSB Number:

Email for remittance:

Signature

Date

/ /

Name of Signee:

Position of Signee:

How to contact us

- Phone: 13 10 10
- Web: gio.com.au
- Email: wcclaimswa@gio.com.au
- Post: GPO Box B50, Perth WA 6838

Who we are

This insurance is issued by AAI Limited
ABN 48 005 297 807 trading as GIO