Employer's Report of Injury
Western Australia

QBE Insurance (Australia) Limited NZBN 9429042054160 AFSL 239 545

For the States of Western Australia, ACT, Northern Territory and Tasmania. Pursuant to the Workers Compensation legislation in force in the State or Territory for which this cover is proposed. Return completed form to: **Western Australia**, GPO Box N1116, Perth WA 6843; **ACT**, PO Box 1008, Civic Square 2608; **Northern Territory**, GPO Box 1659, Darwin NT 0800; **Tasmania**, GPO Box 1352, Hobart 7001

Office use only

Policy number	Risk number	Cost centre code

This form is to be completed by the Employer immediately after the occurrence and should be accompanied by your employee's Workers Compensation Claim Form and First Certificate of Capacity. To ensure early reimbursement of compensation, please complete the section on Income Compensation.

Employer details

Business name					
Employer's ABN					
Address		State	NSW	Postcode	
Postal address		State	NSW	Postcode	
Telephone		Email			
Nature of business					
	Number of employees engaged in the business		Total weekly payroll	$	

Injured person details

Surname		Given names		Date of birth	/ /
Address			State NSW	Postcode	
Industry in which employed		Occupation		Date first employed	/ /
What occupation was the worker engaged in at the time of the accident?					

Was the worker employed: (a) Directly ☐ If directly employed: (i) Full-time ☐ (ii) Part-time ☐ (iii) Casual ☐

(b) As a contractor or subcontractor ☐ (c) By a contractor or subcontractor ☐

(d) Under a temporary visa ☐ Type of visa, e.g. 457

If in your direct employ, for years Please indicate whether the worker has paid employment with another employer Yes ☐ No ☐

Is the injured worker: Right-handed? ☐ Left-handed? ☐

Married, de facto or single	Single	Meal breaks between hours off	
Number of dependent children under 15 years		Number of hours worked each day	
Number of days worked per week		Is board and lodgings provided in addition to weekly wages?	
Hours worked per week		Did the worker continue to work after the accident?	
Usual days off during week		Length of time worked on day when injury occurred	

Injury details

Day of week | Date / / | Time a.m. p.m.

Exact place or location where injury was sustained

Did injured person give notice of injury? Yes ☐ No ☐ | To whom was it given? | If "No", why?

When was it given? a.m. p.m. | On (date) / / | Verbally ☐ In writing ☐

Name of witnesses to the accident, persons in the vicinity or aware of the accident (witness statement(s) to be attached to email if obtained):

Give full details of how injury was sustained:

What is the nature of the injury?

If injury was caused by any person(s) not in your employ, give full names and addresses of those concerned and the name and address of their employer:

Has worker discontinued duties? Yes ☐ No ☐ If "Yes", Date / / Time a.m. p.m.

Has worker returned to full work duties? Yes ☐ No ☐ If "Yes", Date / / Time a.m. p.m.

What is the estimated time of absence from work?

Is compensation being claimed from any other source? Yes ☐ No ☐

If "Yes", please specify:

Injury details (continued)

Supplementary remarks:

Income compensation details

Weekly income compensation rates are based on the worker's pre-injury weekly rate of income as defined in the *Workers Compensation and Injury Management Act 2023*. The income compensation rate will be calculated by QBE Insurance and provided to you once the claim has been lodged. Do not commence payment of income compensation until notified by us.

Please provide a printed wage summary along with the details below.

Name of award or agreement under which worker is paid, or which underpins their employment	
Worker's job classification under that award	

Total GROSS earnings for the 52 weeks immediately prior to the date of injury	$
Was any leave without pay taken during this period? If so, please advise the number of weeks	
If the worker has been employed by you for less than one year state the number of weeks employed by you	

Declaration

Having made an independent investigation into this claim, I certify that the above particulars are correct.

Employer's signature	X	Date	/ /
Name and position of signee			
Name of rehabilitation contact			

No compensation is to be paid until authority from QBE has been obtained.

Important Information for Employers

1. Seven day time limit

You have a statutory obligation to lodge the Worker's Claim form and First Certificate of Capacity, with QBE within seven days of you receiving the Worker's Claim form and First Certificate of Capacity.
Failure to lodge the forms with QBE within seven days of claim notification can result in penalties pursuant to the *Workers Compensation & Injury Management Act 2023*.

2. Completing and sending in this form

Please complete every section of this form. Do not forget to provide the worker's earnings for 52 weeks prior to the injury.
Please attach the Worker's Claim form and the First Certificate of Capacity to this form or QBE will be unable to process the claim.
Please send this form to QBE, GPO Box T1750, Perth 6845 , or via email to mywcclaim@qbe.com. Please ensure you include "New Claim" and your policy number in the subject heading.

3. Payment of income compensation and medical accounts

Under no circumstances should you pay either income compensation or medical accounts in respect of a worker's claim unless authorised by QBE. We will calculate the weekly rate of income compensation and let you know how much to pay. All medical accounts must be forwarded directly to QBE for consideration and payment. QBE will only reimburse accounts at the authorised Workcover rate which can be less than that charged in the account. Therefore, both employers and workers should avoid direct payment.

4. Rehabilitation

Pursuant to WorkCover requirements, if the treating medical practitioner has indicated that the worker has some capacity for work, you are required by law to develop a return to work (RTW) program. You can contact QBE for assistance with the RTW program. Please ensure that you provide QBE with the name of the person responsible for rehabilitation in your company.

5. General enquiries

If you have any concerns or queries about a worker's claim or completing this form please call the Workers Compensation Department of QBE Insurance on (08) 9213 6100.