WORKERS' COMPENSATION - EMPLOYER'S REPORT FORM

It is essential that this form be completed to enable the worker's entitlement to compensation to be promptly determined. Payments should not be commenced until authorised by us. The form should be completed and returned to WFI within 7 days of receipt, via email workerscompclaims@iag.com.au.

If claiming for medical and health expenses and no time has been lost, complete all questions except question 15. Please use "BLOCK" capitals and answer all questions 'X' where applicable (provide full and complete answers). If a particular question does not apply, please write 'Nil' in the space provided. If the space below is insufficient to advise all the details, please attach a separate sheet.

POLICY NUMBER

1. Employer details

FULL NAME OF EMPLOYER

TRADING NAME OF EMPLOYER

TYPE OF BUSINESS

ABN

ADDRESS

POSTCODE

BUSINESS TELEPHONE NUMBER

FACSIMILE NUMBER

CONTACT NAME

EMAIL

MOBILE NUMBER

2. Injured worker details

SURNAME

GIVEN NAME(S)

ADDRESS

POSTCODE

WORKER'S OCCUPATION

TELEPHONE NUMBER

EMAIL

MOBILE NUMBER

Age

DOB D D / M M / Y Y

Relationship (if any) to employer

3. Accident details

Date of accident D D / M M / Y Y

Time AM/PM

Day of week

How long had the worker worked, on the date of the accident, before the injury? HRS MINS

Date work ceased D D / M M / Y Y

Time AM/PM

Date First certificate of capacity received by employer D D / M M / Y Y at AM/PM

Date claim form received from worker D D / M M / Y Y at AM/PM

Was the worker affected by alcohol or drugs? No ○ Yes ○

4. Nature of injury

Report the 'Type of injury' (e.g. fracture, sprain, amputation, etc.) and under 'Part of body' report, as precisely as possible, the part of the body injured. Where multiple injuries are received, report 'Type of injury' the nature and 'Part of body' of each injury and, where known, indicate which injury is the most severe.

	TYPE OF INJURY (E.G. LACERATION, SPRAIN, ETC.)	**PART OF BODY** (E.G. HEAD, LOWER BACK, ETC.)	**SIDE OF BODY** (E.G. LEFT/RIGHT)
1			
2			
3			

Did the worker have any pre-existing injuries or disabilities of a similar nature as noted above?

No ○ Yes ○ ▶ Please provide details

5. Incapacity as a result of injury

Provide details as known at the time of completing this report. '**Totally unfit**' relates to claims where the worker is considered to be totally incapacitated for any type of work. '**Partially unfit**' relates to claims where the worker is fit to undertake restricted duties or hours.

Please cross (X) in the appropriate box. Fatal ○ Partially unfit ○ Totally unfit ○ No time lost ○

Has the worker resumed work? Yes ○ ▶ Date D D / M M / Y Y

No ○ ▶ Estimated period of incapacity Weeks Days

Has the worker returned to full pre-injury hours? Yes ○ No ○

Do you have any other duties which the worker could perform until they can resume their pre-injury duties?

No ○ Yes ○ ▶ Please provide details

6. Cause of accident

Indicate with a cross (X) the occurrence that gave rise to the accident.

a. Undertaking normal duties – Normal workplace ○

b. Undertaking normal duties – Not normal workplace ○

c. Undertaking normal duties – Working from home ○

d. Undertaking normal duties – Road traffic accident ○

e. Commuting/Journey ○

f. During meal or other work break – Normal workplace ○

g. During meal or other work break – Not normal workplace ○

h. Other duty – Please specify

7. Address where accident took place

Address POSTCODE

Was the worker working at your premises or elsewhere? If working elsewhere, please provide full details of the occupier/owner of the premises where they were injured.

8. Department/section where the worker was employed (e.g. welding shop)

9. State the actual process in which the worker was engaged at the time of accident
(e.g. cleaning machinery, ploughing, etc.)

10. Describe concisely all the circumstances of the accident
Ensure that the type of accident and the agency causing it are detailed

Type of accident - is the manner in which the injury occurred (e.g. fall, struck by falling object, caught in or between objects, contact with harmful substances, etc.)

Agency - refers to the working environment (machine, means of transport, substance, etc. causing the accident, e.g. conveyor failed.)

11. Please indicate whether

		No	Yes
a.	any machinery/equipment was involved in the accident?	○	○
	If **Yes**, please provide a full and precise description of the machinery/equipment and who owned the machinery/equipment?		
b.	there was any breach of any statutory or other regulations at the time of injury?	○	○
	If **Yes**, please provide details		
c.	there was any serious and wilful misconduct on the part of the worker which contributed to the injury?	○	○
	If **Yes**, please provide details		
d.	the injury was caused by the negligence of any person?	○	○
	If **Yes**, give details		

12. Reporting of the accident

Name of person to whom the accident was reported

Date reported D D / M M / Y Y Time AM/PM Occupation

13. Witness/Co-worker details

Name of witness/co-worker

Employed by

ADDRESS OF WITNESS/CO-WORKER

POSTCODE

OCCUPATION

If more than one witness, please attach a list on a separate page.

14. Employment details

Date first employed D D / M M / Y Y

Indicate with a cross (X) the days usually worked each week.

Monday ◯ Tuesday ◯ Wednesday ◯ Thursday ◯ Friday ◯ Saturday ◯ Sunday ◯

State standard number of hours worked: Per day HRS MINS Per week HRS MINS

Is this worker subject to a Visa? No ◯ Yes ◯ ▶ What type of visa? e.g. S457

1. Was the worker directly employed? (i.e. not a contractor or employee of a contractor) Yes ◯ No ◯ ▶ Please provide details

2. Which of the following covers the status of the worker's employment?

Full time ◯ Number of hours per week

Part time ◯ Number of hours per week

Casual ◯ The number of weeks they have worked for you over the past year

Seasonal ◯ Length of season in weeks over 12-month period

Working Director ◯

15. Worker's earnings

This section is only required to be completed if the injured worker is certified unfit or has a restricted capacity for work.

To enable us to calculate this worker's income compensation rate please provide details of their past earnings.

a. We require copies of the **wage history or in the absence of being able to do so, the individual pay slips** for the period of 1 year **before** the date of injury, breaking down all allowances paid by each pay cycle. *We require this information to verify whether any allowances have been paid on a "regular basis".*

If employed **less than 1 year** we only require copies of the **wage history/pay slips** for the period beginning on the day on which the worker commenced to be employed in that position and ending on the day before the injury.

b. Is the worker paid under an Industrial instrument (award/industrial agreement) Yes ◯ No ◯ ▶ Please provide details

Industrial instrument means, according to the employment in the context of which the term is used —

a. an award or order (including an enterprise order or General Order) made by The Western Australian Industrial Relations Commission under the *Industrial Relations Act 1979*; or

b. an industrial agreement, as defined in the *Industrial Relations Act 1979* section 7(1); or

c. a fair work instrument, as defined in the *Fair Work Act 2009* (Commonwealth) section 12; or

d. an award, order, agreement or other instrument that is of a class prescribed by the regulations;

If the worker is paid under an industrial instrument, please complete the information below.

Name of Industrial instrument (award/industrial agreement)	
Base award rate	
Base award hours	

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

16. Employer's Declaration

Do you agree with the details of the occurrence as provided on the workers' compensation claim form?

Yes ◯ No ◯ ▶ Please provide details

SIGNATURE OF THE EMPLOYER

DATE D D / M M / Y Y

OFFICIAL POSITION

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

17. Employer electronic funds transfer authority

The following authority authorises WFI to credit the nominated bank account in connection with payments relating to this claim.

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

Please provide the following information:

FULL NAME

POSTAL ADDRESS

POSTCODE

CONTACT TELEPHONE

FACSIMILE

EMAIL

BANK NAME

ACCOUNT NAME

ACCOUNT NUMBER

BSB NUMBER :

Please send confirmation of EFT payments by (select one)

POST ◯ FACSIMILE ◯ EMAIL ◯

I/We authorise, and request, WFI to credit the above bank account number with any amounts in connection with the claim number stated.

SIGNED

DATE D D / M M / Y Y

SIGNED

DATE D D / M M / Y Y

Any personal information you provide to us will be collected, stored, used and disclosed in accordance with our Privacy Policy located at www.wfi.com.au/privacy. Additionally, any sensitive information will only be used for the primary purpose for which it is collected. If you cannot access our Privacy Policy through our website, please contact us on 13 15 32 and we will send you a copy.