NOTIFICATION OF INJURY

This form is to be completed when an injury occurs in the workplace and you would like to notify us of the details.

Please complete this form within 48 hours of the injury occurring and email it to workerscompclaims@iag.com.au or fax it to 1300 038 395.

Please ensure you answer all questions in full, where applicable. If a particular question does not apply, please write N/A in the space provided. If additional space is required, please attach a separate sheet.

This is a notification only and further supporting information is required to lodge a claim, please contact us or visit our website for information on lodging a claim.

Employer details

POLICY NUMBER

COST CENTRE/DEPT CODE

ABN

NAME OF EMPLOYER

ADDRESS

POST CODE

CONTACT PERSON

TELEPHONE NUMBER

EMAIL ADDRESS

Insured person details

MR ☐ MRS ☐ MISS ☐ GENDER ☐ MALE ☐ FEMALE ☐ DATE OF BIRTH D D / M M / Y Y

SURNAME

FIRST NAME

ADDRESS

POST CODE

TELEPHONE NO.

EMAIL ADDRESS

Injury/accident details

DATE OF INJURY D D / M M / Y Y

TIME OF INJURY

WAS THERE ANY TIME LOST FROM THIS INCIDENT? YES ☐ NO ☐

IF SO, PLEASE ADVISE:

THE DATE CEASED WORK: D D / M M / Y Y

THE DATE RESUMED WORK (IF APPLICABLE) D D / M M / Y Y

IF RESUMED WORK, PLEASE CONFIRM:

☐ RETURNED TO PRE-INJURY ROLE ☐ AT WORK NORMAL HOURS, SUITABLE DUTIES ☐ AT WORK ON REDUCED HOURS & DUTIES

IS THIS INCIDENT LIKELY TO BECOME A CLAIM? YES ☐ NO ☐

DESCRIBE HOW THE INJURY OCCURRED

DESCRIPTION OF INJURY & BODY LOCATION (EG. STRAINED BACK, LACERATED FINGER)

ADDRESS WHERE INCIDENT OCCURRED

POST CODE

WERE THERE ANY WITNESSES TO THE INCIDENT? YES ☐ NO ☐ IF YES, PLEASE ADVISE:

CONTACT PERSON

POSITION

TELEPHONE NUMBER

EMAIL ADDRESS

Treating doctor details

NAME OF TREATING DOCTOR & ADDRESS

POST CODE

TELEPHONE NUMBER

EMAIL ADDRESS

HOSPITAL NAME & ADDRESS (IF HOSPITALISED)

POST CODE

Treatment details

WHAT TREATMENT WAS PROVIDED

HAS TREATMENT CEASED YES ☐ NO ☐

Declaration

I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge.

NAME OF NOTIFIER

SIGNATURE

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.