QBE Insurance (Australia) Limited
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Employer's Report of Injury Western Australia

Policy No.		Risk No.		Cost Centre Code	

This form is to be completed by the Employer immediately after the occurrence and should be accompanied by the employee's Claim for Compensation and First Medical Certificate. Please read carefully the explanation on page three of this form regarding weekly compensation calculation. To ensure early refund of compensation this area must be completed.

Employer Details

Business Name					
Employer's ABN					
Address					
		State		Postcode	
Postal Address					
		State		Postcode	
Telephone	( )	Facsimile	( )	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	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? ☐

Previous claims with all employers (for same injured person). Give details.

Married or Single	Number of dependent children under 15 years	Number of days worked per week	Hours worked per week	Usual days off during week	Meal breaks between hours off	Number of hours worked each day	Is board and lodgings provided in addition to weekly wages?	Did the worker continue to work after the accident?	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 ☐		To whom was it given?		
	No ☐		If "No", why?		
When was it given?	a.m. p.m.	on		Verbally ☐	In writing ☐

Name of witnesses to the accident, persons in the vicinity or aware of the accident (witness statement(s) to be attached 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.

After reading carefully the explanatory notes below please complete the schedule

Weekly compensation rates are based on the 'weekly earnings' as defined in the *Workers Compensation and Injury Management Act 1981* (as amended).

Award Workers

If a worker is paid pursuant to an Industrial Agreement, Industrial Award, Certified Agreement, Australian Workplace Agreement or Enterprise Bargaining Agreement, the first 13 weeks of compensation shall be paid on the basis of the average weekly earnings for the 13 working weeks immediately prior to the date of the incapacity, and thereafter at the worker's basic award rate, plus any regular over award payment and any allowances paid on a regular basis as part of the worker's earnings and related to the number and pattern of hours worked. The maximum weekly compensation rate payable is prescribed by WorkCover WA.

Non Award Workers

If a worker is not paid pursuant to an award as noted above, the first 13 weeks of compensation shall be paid on the basis of the average weekly earnings for the 52 working weeks immediately prior to the date of the injury, and thereafter at the amount which is 85% of the 52 weeks' average. If the worker has not been employed for 52 weeks prior to the injury, please indicate number of weeks worked and total earnings.

Casual and Seasonal Workers

Please indicate number of weeks worked and total earnings.

Schedule – Please complete Section A or B

and provide a PRINTED WAGE SUMMARY indicating the total gross earnings for the relevant period prior to the date of injury.

A – Award Workers

Name of Award or Agreement under which Worker is paid						
Worker's Job Classification under that Award						
Base GROSS Award Weekly Rate of Pay and hours (not including overtime, bonuses or allowances)					$ (per week)	
					(hours per week)	
Type and amount of regular over award payment, bonus or allowance.	Type					
	Amount per week	$	$	$	$	$
Total GROSS earnings for the 13 weeks immediately prior to the date of incapacity					$	
Important: If the worker did not work for part of the 13 weeks, e.g. due to sick or annual leave, please disregard that period and state the number of weeks worked.					Total No. of weeks:	

B – Non Award Workers

Total GROSS earnings for the 52 weeks immediately prior to the date of injury	$	
If the worker has been employed by you for less than one year state the number of weeks employed by you		
Seasonal Workers		
Total GROSS earnings in past 12 months whilst employed with you	$	
If employed for less than 52 weeks the number of weeks employed by you		

Declaration

If payment is recommended please sign this form. If not, please sign and attach a statement providing reasons.

Having made an independent investigation into this claim, I certify that the above particulars are correct, and recommend payment of compensation.

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. Three day time limit

You have a statutory obligation to lodge the Worker's Claim form and First Medical Certificate, with QBE within three days of you receiving the Worker's Claim form and First Medical Certificate.

Failure to lodge the forms with QBE within three working days of claim notification can result in penalties pursuant to the Workers Compensation & Injury Management Act 1981.

2. Completing and sending in this form

Please complete every section of this form. Do not forget to provide the worker's earnings for either 13 weeks or 52 weeks prior to the injury depending on whether he/she is employed under an Award or not.

Please attach the Worker's Claim form and the First Medical Certificate to this form or QBE will be unable to process the claim.

Please send this form to QBE, GPO Box T1750, Perth 6845.

3. Payment of weekly benefits and medical accounts

Under no circumstances should you pay either weekly benefits or medical accounts in respect of a worker's claim unless authorised by QBE.

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 will be off work for three days or more, or is unable to return to normal duties, you should complete the "Details to be Provided to Medical Practitioner" section on the Worker's Claim form and fax it to the treating medical practitioner within two working days.

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**.

QBE