CGU Workers Compensation

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.

If claim for medical expenses and no time has been lost, complete all questions except questions 14. Please use "BLOCK" capitals.

Policy no. : : | : : : : : : | :

Risk Codes (if applicable)

1. Employer details

Full name of employer

Trading name of employer

Type of Business

Address

Postcode

Business telephone no. ( )

Facsimile no. ( )

Contact name

Email address

2. Injured worker

Surname

Given name(s)

Address

Postcode

Private telephone no. ( )

Worker's occupation

Age

Date of birth / /

Married: No ☐ Yes ☐

Relationship (if any) to employer

3. Accident

Date of accident / /

Time am/pm

Day of week

How long had the employee worked, on the date of the accident, before the injury? hrs mins

Date work ceased / /

Time am/pm

Date first Medical Certificate received by employer / / at am/pm

Date claim form received from worker / / at am/pm

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

4. Nature of injury

Under '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 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.		

5. Result of injury

Enter the result as known at the time of completing this report. 'Permanent total disability' relates to claims where the worker is considered to be totally and permanently incapacitated for any type of work. 'Permanent partial disability', relates to cases of complete or partial loss of, or loss of the use of, any part of the body or body faculty, as a result of which, although able to work, the earning capacity of the worker, or his/her opportunities for employment (in his/her normal occupation or in any other capacity), are permanently affected.

Please tick (✓) in the appropriate box. Death ☐ Permanent total disability ☐
Temporary disability ☐ Permanent partial disability ☐

Has the worker resumed work? Yes ☐ Date / /

No ☐ Estimated period of incapacity – Weeks Days

Have you any other duties which the worker could perform until he/she can resume his/her pre-injury duties?

No ☐ Yes ☐ Please provide details

6. Cause of accident

Indicate with a tick (✓) the occurrence that gave rise to the accident.

a) Arising out of or in course of employment - during meal or other work break. ☐
b) Arising out of or in course of employment - road traffic accident [other than 6(a), (d) or (e)]. ☐
c) Arising out of or in course of employment - other. ☐
d) Away from work during recess period. ☐
e) On periodic or other prescribed journey. ☐

7. Address where accident took place

Address

Postcode

8. Department/section, etc. 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 and ensure that the type of accident and the agency causing it are reported

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

a) the injury caused by any defect in system of work, machinery or plant.
No ☐ Yes ☐ Please provide details

b) there was any breach of any statutory or other regulations at the time of injury.
No ☐ Yes ☐ Please provide details

c) any serious and wilful misconduct on the part of the worker which contributed to the injury.
No ☐ Yes ☐ Please provide details

d) the injury was caused by the negligence of any person.
No ☐ Yes ☐ Please provide details

12. Reporting of accident

Name of person to whom the accident was reported

Date reported / /

Time am/pm

Name of witness, if any

Address of witness

Postcode

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

Do you agree with the details of the occurrence as provided on the Worker's Claim for Compensation Form?

Yes ☐ No ☐ Please provide details

13. Employment details

Date first employed / /

Indicate with a tick (✓) 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 ☐ No. of hours per week

Part Time ☐ No. of hours per week

Casual ☐ The number of weeks he/she has worked for you over the past year

Seasonal ☐ Length of season in weeks over 12 month period

14. Worker's earnings

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

For award workers we require 13 weeks past earnings before the date of incapacity. If employed less than 13 weeks, we only require the past earnings over the period of employment with you. You will also need to complete the details of the Award or Agreement requested below*.

For non-award workers we require 12 months past earnings before the date of injury including all bonuses and allowances. If employed for less than 12 months, we only require the past earnings over their period of employment including the number of weeks employed by you.

Award

Period	Gross Amount
Week 1	$
Week 2	$
Week 3	$
Week 4	$
Week 5	$
Week 6	$
Week 7	$
Week 8	$
Week 9	$
Week 10	$
Week 11	$
Week 12	$
Week 13	$

Non Award

Period	Gross Amount
Month 1	$
Month 2	$
Month 3	$
Month 4	$
Month 5	$
Month 6	$
Month 7	$
Month 8	$
Month 9	$
Month 10	$
Month 11	$
Month 12	$

Award or Enterprise Agreement

Name of Award or Enterprise Agreement	
Base Award Rate and Hours	
Over award amount paid on a regular basis (excluding allowances)	
Shift Allowance	
Bonus	
Casual Allowance	
Other Allowances (otherwise not specified)	

Please sign this form if you agree with the circumstances of the accident

Signature of the employer | **Date** / / | **Official position**

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