ZURICH®

Employer's Report of Injury

1 Employer details

Policy number | Cost centre | Risk number

Name of policyholder

Trading name

Postal address | Postcode

Location address (specify number, street, suburb)

Phone number | Fax number

Business (type of activity or profession)

Number of employees

2 Employer contact person dealing with Workers' Compensation claim / Injury Management

Name | Position

Phone number | Fax number

Email

Address | Postcode

3 Worker's employment details

Full name of worker – Surname | First names

Residential address | Postcode

Gender – Male ◯ Female ◯ | Date of birth / / | Marital Status – Married ◯ Single ◯ Defacto ◯ Divorced ◯

Date first employed / / | Occupation

Main tasks performed by worker

Is the worker employed – Full time ◯ Part time ◯ Casual ◯ Other ◯ Sub-contractor ◯ Contractor ◯ Visa ◯

Is the worker a direct employee? Yes ◯ No ◯ | If 'No', explain employment

Is the worker a member of the employer's family? Yes ◯ No ◯ | If 'Yes', do they reside with the employer? Yes ◯ No ◯

Is the worker employed by anyone else? Yes ◯ No ◯ | If 'Yes', provide name and address

Is the worker a working director? Yes ◯ No ◯ | If 'Yes', are they declared on the policy Yes ◯ No ◯

4 Injury details (Please complete all particulars)

Are you satisfied that the information in the Employee Claim Form under the sections headed 'Occurrence Detail' and 'Occurrence Report' are correct? Yes ◯ No ◯

If 'No', please provide details

Have you contacted the treating doctor? Yes ◯ No ◯

Zurich Australian Insurance Limited ABN 13 000 296 640, AFS Licence No: 232507. Head Office: 5 Blue Street, North Sydney NSW 2060. Regional Office: Level 2, 58 Kings Park Road West Perth WA 6005. PO Box 442 West Perth WA 6872, Phone 08 9261 1599, Fax 08 9261 1390.

5 Give details of other circumstances that may assist Zurich to assess the claim

Include queries as to the validity of the claim eg. misconduct, skylarking or pre-existing medical conditions contributing to the injury or incident.

6 Compensation details

Did the worker cease work because of the injury? Yes ◯ No ◯ If 'Yes', when? / / Time am ◯ pm ◯

Has worker resumed work? Yes ◯ No ◯ If 'Yes', when? / / Time am ◯ pm ◯

What is the exact time lost – Weeks Days Hours (To date of completion of form if work has not been resumed)

7 Wage information – (Complete only when claiming for lost time)

Is the worker employed under (please ✔ tick the appropriate box)

Federal award ◯ State award ◯ Registered EBA ◯ Unregistered EBA ◯ Agreed rate ◯ Workplace agreement ◯

Note: If agreed or market rate please confirm whether this was negotiated with reference to an award.

Award classification name

EBA title

How many hours does the worker work per week? How many days are worked per week?

Basic/award hours per week (eg 38 hrs) Normal start time am ◯ pm ◯ Finish time am ◯ pm ◯

Are there any rostered day off? Yes ◯ No ◯ If 'Yes', which days?

Award Workers

Please provide a detailed payroll print-out for the 13 weeks earnings immediately prior to the date of injury.

Gross 13 weeks earnings $ Base award rate $

Non Award Workers

If the worker is not employed under an award classification or Registered EBA, please provide details of the total gross earnings paid to the worker over the last 12 months immediately prior to the date of the injury.

$

If not 52 weeks please confirm the dates worked / / to / / Number of weeks worked

8 Safety equipment – (Where applicable to the tasks which resulted in the injury)

Had the worker been provided with safety equipment or clothing at the time of the incident eg. glasses, boots, harnesses? Yes ◯ No ◯

If 'Yes', was it being worn / used at the time of the incident? Yes ◯ No ◯ If 'No', state why not?

9 Injury Management / Rehabilitation – (Please complete every particular in this section)

Do you have a written established injury management system? Yes ◯ No ◯

Do you have any alternative duties the worker can perform until pre-injury fitness is achieved? Yes ◯ No ◯

Do you have a written established return to work program for injured workers? Yes ◯ No ◯

Do you require further information to assist in establishing an injury management system or return to work program? Yes ◯ No ◯

10 Employer declaration

I (print name and position)

declare that the details above are true and correct in every particular.

Signature of employer or authorised person Date

✗ / /

Information for Employers

Privacy statement and consent

Zurich is bound by the *Privacy Act 1988*. We collect, disclose and handle information, and in some cases personal or sensitive (eg health) information, about you ('your details') to manage and investigate claims, administer policies, comply with our legal obligations, contact you and enhance our products and services ('Purposes'). If you do not provide your information, we may not be able to do those things. By providing us, our representatives or your intermediary with information, you consent to us using, disclosing to third parties and collecting from third parties your details for the Purposes.

We may disclose your details, including your sensitive information, to relevant third parties including your intermediary, policy owners, affiliates of Zurich Insurance Group Ltd, insurers, reinsurers, our service providers, our business partners, health practitioners, your employer, parties affected by claims, government bodies, regulators, law enforcement bodies and as required by law, within Australia and overseas.

We may obtain your details from relevant third parties, including those listed above. Before giving us information about another person, please give them a copy of this document. Laws authorising or requiring us to collect information include the *Insurance Contracts Act 1984*, *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*, *Corporations Act 2001*, *Autonomous Sanctions Act 2011*, *A New Tax System (Goods and Services Tax) Act 1999* and other financial services, crime prevention, trade sanctions and tax laws.

Zurich's Privacy Policy, available at www.zurich.com.au or by telephoning us on 132 687, provides further information and lists service providers, business partners and countries in which recipients of your details are likely to be located. It also sets out how we handle complaints and how you can access or correct your details or make a complaint.

Employers – Please note

1. This Report of Injury form must be forwarded to Zurich within three days of the worker giving you a First Medical Certificate and Workers' Claim Form. All these forms should be sent to: Zurich Australian Insurance Limited, PO Box 442, West Perth WA 6872. Fines can be imposed for late notifications.
2. If the worker has not resumed work at time of lodgement of this claim, it is important that you notify Zurich when work is resumed.
3. **No weekly compensation payments are to be made without prior approval from Zurich and only after receipt of a covering medical certificate in the form prescribed under the Workers' Compensation and Injury Management Act 1981 (WA) (the Act).**
4. Weekly compensation will only be reimbursed at the rates advised by Zurich.
5. Medical accounts should be sent unpaid to Zurich.
6. **Section 84AA – Employer to keep position available during workers' incapacity:**

   Where a worker who has been incapacitated by injury attains partial or total capacity for work in the 12 months from the day the worker becomes entitled to receive weekly payments of compensation from the employer, the employer shall provide to the worker:

   (a) the position the worker held immediately before that day if it is reasonably practicable to provide that position to the worker; or

   (b) if the position is not available, or if the worker does not have the capacity to work in that position, a position

      (i) for which the worker is qualified; and

      (ii) that the worker is capable of performing.

   Most comparable in status and pay to the position mentioned in paragraph (a). **(Penalty: $5000).**
7. **Section 84AB – Employer to notify worker and WorkCover WA of intention to dismiss worker:**

   An employer must not dismiss a worker to whom Section 84AB(1) applies unless the employer has given to the worker and to WorkCover WA in accordance with subsection (2) a notice of intention to dismiss the worker, in the required form not less than 28 days before dismissal. **(Penalty: $2000).**
8. Section 155C requires an employer to establish a return to work program as soon as practicable if a worker's treating doctor advises the employer in writing that a program is necessary or the doctor signs a medical certificate that the worker has total or partial capacity to return to work.

   The employer must ensure that the establishment, content and implementation of a return to work program are in accordance with the code of practice. Under section 155D an employer may request in writing that their insurer assist in establishing a return to work program for a worker.
9. WorkCover WA has developed guidance notes to accompany the Code of Practice (Injury Management) that contains a template for an Injury Management System. The template illustrates that an Injury Management System can be a set of simple steps that provide for appropriate action to be taken by an employer when a workplace injury occurs.

   Employers who use the Injury Management System template would meet the requirements of Section 5 of the Code of Practice. For further information visit WorkCover WA's internet site at www.workcover.wa.gov.au or contact the WorkCover Infoline on 1300 794 744.
10. Please telephone Zurich if you have difficulty completing this form or any other questions.