



Employer's Report of Injury

DO YOU SUPPORT THIS CLAIM Yes No

Important Please Read

Level 9, 66 St Georges Terrace, Perth WA 6000. GPO Box B50 Perth WA 6001. Telephone (08) 9320 3600 Facsimile (08) 9320 3650

COMPLETE ALL QUESTIONS, PARTIALLY COMPLETED FORMS WILL BE RETURNED. (Print in block letters and circle where appropriate.)

Employer details

| | | | |
|--|----------------------|---------------|----------------------------------|
| Full name as per policy | <input type="text"/> | | |
| Trading Name | <input type="text"/> | Policy No. WA | <input type="text"/> |
| Telephone No. | <input type="text"/> | Fax No. | <input type="text"/> |
| | Email | | <input type="text"/> |
| Postal Address: | <input type="text"/> | | Postcode <input type="text"/> |
| Name of Site and/or Location address where injured person actually works | <input type="text"/> | | Cost centre <input type="text"/> |
| Business Activity/Profession (use 2 words or more) | <input type="text"/> | | |

Injured person's details

| | | | | | |
|---|--|-----------------------------|--|--|------------------------------|
| Surname | <input type="text"/> | Given Names | <input type="text"/> | | |
| Address | <input type="text"/> | | | | |
| | <input type="text"/> | Postcode | <input type="text"/> | Telephone No. | <input type="text"/> |
| Date employed | <input type="text"/> / <input type="text"/> / <input type="text"/> | Place of birth | <input type="text"/> | | |
| Date of birth | <input type="text"/> / <input type="text"/> / <input type="text"/> | Height | <input type="text"/> | Weight | <input type="text"/> |
| Sex: Male | <input type="checkbox"/> | Female | <input type="checkbox"/> | Employed: Full Time | <input type="checkbox"/> |
| | | | | Part Time | <input type="checkbox"/> |
| | | | | Casual | <input type="checkbox"/> |
| | | | | Marital Status: Married/De facto | <input type="checkbox"/> |
| | | | | Single | <input type="checkbox"/> |
| Occupation | <input type="text"/> | | Is injured person a contractor or subcontractor? | Yes | <input type="checkbox"/> |
| | | | | No | <input type="checkbox"/> |
| <i>(If "YES", attach a copy of any written agreement or contract, together with twelve months of their invoices if applicable.)</i> | | | | | |
| Is she/he a director or family member? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please tick which | Director | <input type="checkbox"/> |
| | | | | Family member | <input type="checkbox"/> |
| | | | | If a family member, does she/he live with the Insured? | Yes <input type="checkbox"/> |
| | | | | | No <input type="checkbox"/> |

Injury details

| | | | | | | |
|--|--|--------------------------|---|-----------------------------------|--|--------------------------|
| Date of injury | <input type="text"/> / <input type="text"/> / <input type="text"/> | Time of injury | <input type="text"/> am/pm | Date Employee Claim form received | <input type="text"/> / <input type="text"/> / <input type="text"/> | |
| To whom was accident reported | <input type="text"/> | Position | <input type="text"/> | Date first medical received | <input type="text"/> / <input type="text"/> / <input type="text"/> | |
| Name and address of witness | <input type="text"/> | | | | Postcode | <input type="text"/> |
| Location address where injury occurred | <input type="text"/> | | | | Postcode | <input type="text"/> |
| Where did the accident occur? | At work | <input type="checkbox"/> | During work break | <input type="checkbox"/> | Away from work during a break | <input type="checkbox"/> |
| | Motor vehicle accident whilst working | <input type="checkbox"/> | Travelling to or from place of employment | <input type="checkbox"/> | | |

Injury details continued

How did the injury occur?

What was the injured person doing at this time?

Was the injured person performing his/her normal duties?

Yes No

If "No", why were they doing this task?

Is protective equipment/clothing required for the task?

Yes No

If "Yes", what type?

Was the above clothing/equipment being worn at the time of the injury?

Yes No

If "No", why?

Is this a recurrence/aggravation?

Yes No

If "Yes", provide details of previous injury including the Insurer's claim number if known?

Describe the injured person's injury or condition (e.g. laceration, dermatitis)

Which part of the body is injured (e.g. left upper arm, right ankle)

Was First Aid treatment given?

Yes No

If "Yes", by whom?

What treatment was provided and for what period?

Name of Doctor first attended

Hospital admitted to and date

Give details of any other circumstances that would assist GIO to assess the claim.

(Include in here queries as to the validity of the claim e.g. misconduct, skylarking or pre-existing disabilities contributing to the injury or accident.) In my opinion:

Time loss details (show N/A if there is no lost time)

Date ceased work

Time

Date work resumed

Time

If work has not been resumed what is anticipated date of return

Weekly compensation (complete only if there is or will be lost time [e.g. surgery anticipated])

How many days per week?

and hours per day?

does the injured person work? Yes No

What is the start time?

and finish time?

Is this the same every day? Yes No

If "No", please provide details

Please show whether the injured person is employed under: 1. Industrial Award or 2. Other

If option 1:

What is the full name of the Award?

is it: State or Federal?

Weekly compensation continued

Please also complete the 13 weeks wage information below to enable us to advise you of the correct rate of pay or provide a print-out of payment records.

| Week No | Week Ending | No. of Hours Worked | Award Rate \$ | Overtime \$ | Allowances \$ | Other \$ | Total \$ |
|---------|-------------|---------------------|------------------|-------------|---------------|----------|----------------|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |
| 13 | | | | | | | |
| | | | AVERAGE (+13) \$ | | | | GRAND TOTAL \$ |

If option 2: Please provide the total amount paid to the injured person during the 12 months immediately prior to the accident or for such lesser period as applies and ensure that the "Date Employed" is completed in the "Injured Person's details" section on page 1.

Total "wages" paid \$ for weeks (please provide print out of pay records)

Rehabilitation

The Injury Management Process in Western Australia requires consultation between the employer, the medical practitioner and the injured person before the injured worker is referred to an approved rehabilitation provider for an assessment. An employer is able to authorise their insurer to act on their behalf in the consultation process with the medical doctor to support the employee in their appointment of an approved vocational rehabilitation provider for a vocational assessment.

Do you have a delegated rehabilitation coordinator? Yes No If Yes, name telephone no.

Has injury management commenced? Yes No If Yes, what actions have been taken

Signature Position Date / /

Employer's Declaration

I, (print name, position)

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

EMPLOYERS PLEASE NOTE

- This notice of claim must be forwarded within 3 days of lodgement of claim by the injured person. This also applies to any documentation received in respect of the claim.
 - Please attach Employee Claim Form 2B and 1st Medical Certificate.
- If the injured person has not resumed work at the time of lodgement of this claim, it is important that you notify the insurer immediately the injured person returns to work.
- No compensation or any other payments e.g. medical are to be made without prior written approval of the insurer.



GIO General Limited (ABN 22 002 861 583)