

employer's workers' compensation report of injury/claim report



Please reply to Lumley Insurance
Postal address Locked Bag 1
Bassendean DC WA 6942
Street address 50 St Georges Tce
Perth WA 6000
Telephone (08) 9220 8280
Facsimile (08) 9378 2172

- Note**
1. To avoid penalties that can be imposed on you under section 57A(2) of the Workers' Compensation and Injury Management Act for failure to make a claim within the time prescribed by that Act you must complete and return this report to Lumley Insurance within **five (5)** full working days of being notified of a claim.
 2. All sections of this report must be completed and have attached any available medical certificates and other relevant documents.
 3. **A compensation payment is not to be made until Lumley Insurance give you authority to do so.**

Privacy Personal information provided to us in this document and the information we collect from third parties in connection with your claim will only be used by us to deal with this claim and your future insurance arrangements and claims you might lodge with us. We will only pass the information to persons outside Wesfarmers General Insurance Limited if they are assisting us with the above matters or we are required by law to do so or you consent to our doing so. Please refer to the Privacy Statement on our website (www.lumley.com.au) for more information on how we handle your personal information.

DETAILS ABOUT YOU

Legal entity name _____
Trading name _____
Postal address _____ Postcode _____
Street or location address _____
(If as postal address, write as above) _____ Postcode _____
Business Ph _____ Mobile _____ Facsimile _____ Email _____
Main business or industry activity _____ Policy number _____

DETAILS ABOUT THE INJURED PERSON

Full name in block letters _____ Date of birth _____
Postal address _____ Postcode _____
Street or location address _____
(If as postal address, write as above) _____ Postcode _____
Telephone private _____ Mobile _____
Has the injured person:
(a) a dependent spouse? Yes No
(b) any dependent children? Yes No

DETAILS OF WORKING RELATIONSHIP

Occupation _____ Date service commenced with you _____
Is the service with you
(a) Full time Part time Casual Temporary Permanent
(b) Direct employ Contractor Subcontractor
If the service with you is that of contractor or subcontractor, we will contact you for more information.
Does the injured person work for anyone else? Yes No If Yes, provide name _____
Address _____ Contact telephone _____
Hours worked _____ Rate of pay _____

DETAILS OF WORKPLACE ARRANGEMENT AND REMUNERATION

Indicate which one of the following arrangements applies to the injured person:

- (a) Registered industrial agreement
 Name of agreement _____ State Federal
- (b) Unregistered industrial agreement
- (c) Industrial award
 Name of award _____ State Federal
- (d) Enterprise bargaining agreement
- (e) Enterprise order
- (f) Verbal agreement
 Show the total wages paid by you to the injured person during the 12 month period up to the date of the incident: \$ _____
 Show the number of weeks this is for if the number is less than 52 weeks: _____ weeks
- (g) None of (a) to (f) above

If you have indicated (a) or (c), show the Award hours per week for your industry _____
 and the number of days worked by the injured person per week _____
 and the normal hourly rate of pay _____

You must also now complete the wage information below so that we can calculate the correct rate for compensation payment. Whichever of (a) – (g) you have indicated, we will advise you of the correct rate for compensation payment and if and when payments may proceed.

WAGE INFORMATION FOR THE 13 WEEKS IMMEDIATELY BEFORE THE INCIDENT								
week no	week ending	number hours worked		award rate plus any regular	overtime (o/t) \$	allowances \$	other \$	total \$
		norm	o/t					
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
TOTAL				\$	\$	\$	\$	\$

DETAILS OF INCIDENT

All questions must be answered

When did the incident occur? Date _____ Day _____ Time _____ am/pm

When did the injured person first report the incident to you? Date _____ Day _____ Time _____ am/pm

Did the injured person cease work? Yes No

If Yes Date _____ Day _____ Time _____ am/pm

Is this claim for medical expenses only? Yes No

Has the injured person returned to any employment? Yes No If yes, date: _____
Date _____ With whom _____

In what capacity? (For example, normal duties, light duties) _____

Have you paid the injured person after the date of incident? Yes No

If Yes, to what date have you paid? (See Note 3. on page 1.) Date _____

Where did the incident happen? _____

Is this where the injured person usually works? Yes No If no, where is the usual place? _____

Was there a vehicle involved in the incident? Yes No

(If there was more than one vehicle involved in the incident, provide the information requested here for each additional vehicle on a separate sheet of paper.)

If Yes Make of vehicle _____
Registration number _____
Registered owner _____
Contact telephone _____
Driver _____
Contact telephone _____

Describe what the injured person was doing leading up to the incident and how the incident happened. Please provide full details including the details of any premises, equipment, machinery or other object or animal involved. You must also tell us if there was any misconduct by the injured person or any other person which contributed to the incident.

At the time of the incident, was the injured person doing what they had been instructed to do and were they doing it in the way they had been instructed?

If No, what were they doing which was different to their instructions? _____

Were there any witnesses to the incident? Yes No

(If there was more than one witness provide the information requested here for each additional witness on a separate sheet of paper.)

If Yes Name _____
Address _____

Contact telephone _____

DETAILS OF INJURIES

Describe the injury sustained by the injured person and advise each body part(s) injured.

Has the injured person commenced an Injury Management/Return to Work program? Yes No

If No, why not _____

Did the injured person have any pre-existing injuries or disabilities that may have contributed to the incident or injury or that may extend the general period of recovery for injuries of this type? Yes No Unaware

If Yes, give details _____

Do you have any reason to suspect that the injury suffered by the injured person is not a direct result of the incident that you have described or that the incident or injury is not directly work related? Yes No

If Yes, give details _____

BANKING DETAILS IN CONNECTION WITH PAYMENTS

The following authorisation authorises LI to credit the nominated bank account in connection with payments relating to this claim. This authority remains in force for the duration of the claim unless revoked in writing.

Please provide the following information:

Full name:

Postal address :

Contact telephone:Facsimile:

Email:

Bank name: Account name:

Account number:BSB number:

Please send confirmation of EFT payments by (select one)

Post Facsimile Email

I/We authorise, and request, WFI to credit the above bank account number with any amounts in connection with the claim number stated.

Signed: Date:

Signed: Date:

Any information collected by LI will be handled in accordance with our privacy policy. A copy of that policy can be obtained by visiting our website at www.lumley.com.au or by contacting us on 1300 586 539.

DECLARATION

I hereby declare the foregoing particulars to be true and correct in every respect and that no information has been exaggerated, omitted or withheld.

Print name _____

Position _____

Signature _____

Date _____