WORKERS COMPENSATION
EMPLOYEE'S CLAIM FORM

In order for your Employer or CGU Workers Compensation to access or otherwise deal with your claim we need to collect personal information, including health related information. The information will be kept confidential and will be managed in accordance with our Privacy Policy which can be found on our website at www.cgu.com.au/privacy.

1. Employer details

Name of Employer

Employer contact name

Employer contact phone no.

Employer contact Email

While employed by you I had an injury as described below and I wish to claim compensation under the Workers' Compensation Act.

2. About you

Given name(s)

Surname

Residential address

Postcode

Postal address (if different)

Postcode

Home telephone no.

Mobile no.

Email

Language spoken at home

Country of birth

Date of Birth D D / M M / Y Y

Sex: Male ☐ Female ☐ Interpreter required? No ☐ Yes ☐

Marital status: Single ☐ Married/Defacto ☐ Is spouse/defacto working? No ☐ Yes ☐

Occupation and trade

Do you have other employment?

No ☐ Yes ☐ ▶ Full-time ☐ Part-time ☐

▶ Full name of employer

▶ Address of employer

Postcode

Home telephone no.

3. Dependants details

Please provide details of people who are totally or mainly dependant upon you for support

Name	Relationship	Date of Birth
		D D / M M / Y Y
		D D / M M / Y Y
		D D / M M / Y Y
		D D / M M / Y Y

4. Injury details

Where did the injury occur?

At work ☐ During a break ☐ Vehicle accident while working ☐ Travelling to place of employment ☐

Travelling from place of employment ☐ Away from work during recess period ☐

Other ☐ Give details

The exact location where the injury happened

Date or time it happened/you first noticed the injury

D D / M M / Y Y ☐ a.m. ☐ p.m.

Date or time you stopped work

D D / M M / Y Y ☐ a.m. ☐ p.m.

Date or time you reported it

D D / M M / Y Y ☐ a.m. ☐ p.m.

Name of person you reported it to:

5. Witnesses

Name Address Postcode

Name Address Postcode

6. Incident details

What happened?

Type of injury and part of your body affected

Hospital or doctor that is treating you

Date first sought medical treatment

D D / M M / Y Y

7. Other work related injuries

Have you previously suffered any similar injury/disease injury before?

No ☐ Yes ☐ Describe injury/disease and the parts of the body affected. Give approximate dates.

What is the name of the doctor, medical practice or hospital who treated you at the time?

Have you ever claimed for the injury/disease described?

No ☐ Yes ☐ What is the approximate date(s) of the claim(s). Who was the claim with?

Who were you working with at the time?

8. Journey injury

Complete only if the injury occurred away from your employer's premises or while you were on a journey to from work or a motor vehicle was involved.

Mode of transport at the time of the accident (e.g. car, bus, etc)

Journey to work ☐ Journey from work ☐ Journey to or from trade school ☐ Journey during a recess period ☐

Other ☐ Give details

What time did you leave? What time did you expect to arrive?

If you deviated from your normal journey or if there was an interruption to the journey please explain why.

Were you under the influence of alcohol or other drugs?

No ☐ Yes ☐ Provide details

Was the injury sustained outside the boundary of the land on which your workplace/home is situated? No ☐ Yes ☐

9. Vehicle accident details

Driver ☐ Passenger ☐ Pedestrian ☐ Other ☐

Please provide details of vehicles involved including registration number, name and address of driver

If a motor vehicle accident, has a Compulsory Third Party claim been made?

No ☐ Yes ☐

Was the accident reported to the police?

No ☐ Yes ☐ Name and police station of police officer or name of person reported to

Diagram of accident

10. Employee declaration

I

declare the above statements and particulars are true and correct and that whilst I am in receipt of weekly payments of compensation I am obliged to notify the insurer immediately if I commence employment with some other person, commence my own business or incur any change in my employment that effects my earnings or earning capacity. I am aware that it is an offence to do so.

I agree that, by submitting this form, Any personal information I provide to CGU will be collected, stored, used and disclosed in accordance with CGU's Privacy Policy located at www.cgu.com.au/privacy. Additionally, any sensitive information will only be used for the primary purpose for which it is collected. If you cannot access our Privacy Policy through our website, please contact us on 13 15 32 and we will send you a copy.

I hereby authorise any medical practitioner, rehabilitation provider or other authority to provide the insurer with any and all information regarding my medical and or factual history in respect of the injury sustained.

A photocopy of this authority shall be as valid as the original. **Please forward completed form to your employer.**

Have you attached your medical certificate?

Yes ☐ No ☐ We cannot process your Claim without the medical certificate.

Signature of employee

Date

D D / M M / Y Y

Signature of Employer

Date

D D / M M / Y Y

Date employer received claim

D D / M M / Y Y

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