EMPLOYER'S INDEMNITY
JOURNEY REPORT

Claim number

Policy number

The form should be completed and returned to CGU Workers Compensation within 5 business days of receipt, via email workerscompclaims@iag.com.au. This form should be accompanied by a Workers Compensation Claim Form and a Witness Statement Form, if not already submitted.

In order for your Employer or CGU to assess or otherwise deal with your claim we need to collect certain personal 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.

Please print in block letters and answer all questions X where applicable (provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

Employer details

Name of business

Contact

Employer's address

Postcode

Telephone no.

Mobile no.

Facsimile no.

Email address

Injured person's details

Surname/Family name

First name

Address

Postcode

Claim details

Date of occurrence

D D / M M / Y Y

Time

a.m.

p.m.

Where did the injury occur?

Street

Suburb

State clearly and fully how the accident occurred.

Journey details

Where did the journey commence from?

What was your destination?

What was the purpose of your journey?

Were you under instructions from your employer during the journey? No ☐ Yes ☐ If yes, What were they?

Provide full details of route taken

Is this the normal route for the journey? Yes ☐ No ☐ If no, Why was this route taken?

Prior to the accident, was your journey interrupted for any reason? No ☐ Yes ☐ If yes, What was the reason?

To be completed for all accidents involving a motor vehicle

Driver's details

Name of owner of the vehicle in which you were travelling

Address of owner of the vehicle in which you were travelling

Postcode

Make of vehicle

Registration no.

Driver's name

Driver's address

Postcode

Name of insurance company

Other vehicle's details

Owner's name

Telephone no.

Owner's address

Postcode

Driver's name

Approximate age

Driver's address

Postcode

Make of vehicle | Body type | Registration no.

Name of insurance company

Details of all witnesses

Were there any witnesses to this accident?

No ☐ Yes ☐ ▶ Name | Age | Telephone no.

▶ Address

Postcode

State if the witness was ☐ an independent witness ☐ in the insured vehicle ☐ in the third party vehicle

▶ Name | Age | Telephone no.

▶ Address

Postcode

State if the witness was ☐ an independent witness ☐ in the insured vehicle ☐ in the third party vehicle

Diagram of accident

Using the symbols below draw a diagram of the accident scene showing the position of all vehicles. Indicate by arrows the direction in which the vehicles were travelling, the names of the streets and the north point of the compass. Please identify any other vehicles involved as '2', '3', '4', etc. Show the point of impact so: X. It is important that the sketch be as accurate and as detailed as possible.

Your vehicle | Other vehicle (2) | Pedestrian, Cyclist etc. | Road | Stop sign | Give way sign | Lights

Who, in your opinion was to blame for the accident and why?

Have you reported the accident to the police? No ☐ Yes ☐ ▶ Please provide details:

Where | Report number | Date reported (D D / M M / Y Y)

Were any charges laid or initiated against you or any other person? No ☐ Yes ☐ ▶ If yes, Please state the nature of charges

Have you reported the matter to your state Compulsory Third Party (CTP) Insurer?

No ☐ Yes ☐

Injured person's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief.

I agree that, by submitting this form, the personal information I provide to CGU Workers Compensation in this form or otherwise may be collected, held, used and disclosed in the manner set out in the CGU Privacy Policy found at www.cgu.com.au/privacy, including for processing this claim. To the best of my knowledge and belief, all the information given in this form is true and correct.

Name of injured person

Signature

Date

D D / M M / Y Y

Name of witness

Signature

Date

D D / M M / Y Y

Failure to complete this declaration may delay approval of this claim.

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