IMPORTANT EMPLOYER NOTICE

1. Three day time limit

You have a statutory obligation to lodge this form, together with the Worker's Claim Form and First Medical Certificate, with QBE within 3 days of you receiving the Worker's Claim Form and First Medical Certificate.

Failure to lodge the forms with QBE within 3 working days of claim notification can result in your company being penalised under the ***Workers' Compensation & Rehabilitation Act 1981****.*

2. Completing and sending in this form

Please complete every section of this form. Do not forget to provide the worker's earnings for either 13 weeks or 52 weeks prior to the injury depending on whether he/she is employed under an Award or not.

Please attach the Worker's Claim Form and the First Medical Certificate to this form. Without these two documents, QBE cannot process the worker's claim.

3. Payment of weekly benefits and medical accounts

Under no circumstances should you pay either weekly benefits or medical accounts in respect of a worker's claim unless authorised by QBE.

All medical accounts must be forwarded **directly** to QBE for consideration and payment. QBE will only reimburse accounts at the authorised Workcover rate which can be less than that charged in the account. Therefore, both employers and workers should avoid direct payment.

4. Rehabilitation

Pursuant to Workcover requirements, if the treating medical practitioner has indicated that the worker will be off work for 3 days or more, or is unable to return to normal duties, you should complete the "Details to be Provided to Medical Practitioner" section on the Worker's Claim Form and fax it to the treating medical practitioner within 2 working days.

Please ensure that you provide QBE with the name of the person responsible for rehabilitation in your company.

5. General Enquiries

If you have any concerns or any queries about a worker's claim or completing this form please call the Workers' Compensation Department of QBE Insurance on (08) 9213 6100.

QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035
Perth Branch
95 William Street, Perth
W.A. 6000 Australia
GPO Box T1750, Perth 6845
Telephone: (08) 9213 6100
Facsimile: (08) 9213 6185 / 9213 6199

QBE WORKERS Compensation

Employer's Report

Policy No.

Preliminary Particulars of Occurence of Disability to be furnished by the Employer immediately after the occurence. This form should be accompanied by the employee's Claim for Compensation as well as First Medical Certificate.
Please read carefully the explanation on page 3 of this form regarding weekly compensation calculation.
To ensure early refund of compensation this area must be completed.

Employer

Business Name | Employers ABN

Address | Postcode

Postal Address | Postcode

Telephone | Facsimile | Email

Nature of Business/Occupation of Employer

Number of employees engaged in the business | Total weekly payroll $

The Injured Person

Surname | Given Names | Date of Birth / /

Address | Postcode

Industry in which employed | Occupation | Date first employed / /

What occupation was the worker engaged in at the time of the accident?

Was the worker employed: (a) Directly ☐ (b) As a contractor or subcontractor ☐ (c) By a contractor or subcontractor ☐ If in your direct employ, for ____ years

Is the injured worker Right -handed? ☐ Left -handed? ☐

Previous claims with all employers (for same injured person). Give details

Married or Single	Number of dependent children under 16 years	Number of days worked per week	Hours worked per week	Usual days off during week	Meal breaks between hours off	Number of hours worked each day	Is board and lodgings provided in addition to weekly wages?	Did the worker continue to work after the accident?	Length of time worked on day when injury occurred

Particulars of Accident

Day of week | Date / / | Time a.m. p.m.

Exact place or location where injury was sustained

Did injured person give notice of injury? Yes ☐ To whom was it given?

No ☐ If not, why?

When was it given? a.m. p.m. on Verbally ☐ In writing ☐

Name of witnesses to the accident, persons in the vicinity or aware of the accident (witness statement(s) to be attached)

Give full details of how injury was sustained

What is the nature of the injury?

If injury was caused by any person(s) not in your employ give full names and addresses of those concerned and the name and address of their employer

Has worker discontinued his duties? Yes ☐ No ☐ If 'Yes' Date / / Time a.m. p.m.

Has worker returned to work? Yes ☐ No ☐ If 'Yes' Date / / Time a.m. p.m.

What is the estimated time of absence from work?

Is compensation being claimed from any other source? Yes ☐ No ☐

If yes, please specify

Supplementary remarks as to anything affecting the cause or probable consequence of the injury

AFTER READING CAREFULLY THE EXPLANATORY NOTES BELOW PLEASE COMPLETE THE SCHEDULE

Weekly compensation rates are based on the 'weekly earnings' as defined in the Workers' Compensation and Rehabilitation Act 1981 (as amended).

Award Workers
If a worker is paid pursuant to an Industrial Award, the first **FOUR** weeks of compensation shall be paid on the basis of the average weekly earnings for the 13 working weeks immediately prior to the date of the disability and thereafter at the worker's basic award rate plus any regular over award payment.
Overtime and allowances are included only in the calculation of average weekly earnings for the first FOUR weeks of disability.

Non Award Workers
If a worker is **not** paid pursuant to an Industrial Award, the first **FOUR** weeks of compensation shall be paid on the basis of the average weekly earnings for the 52 working weeks immediately prior to the date of the disability and thereafter at the amount which is 85% of the 52 weeks' average.
If the worker has not been employed for 52 weeks prior to the injury, please indicate number of weeks worked and total earnings.

Casual and Seasonal Workers
Please indicate number of weeks worked and total earnings.

SCHEDULE – PLEASE COMPLETE SECTION A OR B

A – Award Workers

Name of Award or Agreement under which Worker is paid

Worker's Job Classification under that Award

Regular Over Award Payments $ (per week) (provide details of payment types (eg. shift work, overtime, bonus, allowances, etc)

Total earnings for the 13 weeks immediately prior to the date of injury $ (if the worker did not work for part of that 13 weeks disregard that period)

B – Non Award Workers

Total earnings for the 52 weeks immediately prior to the date of injury $

If the worker has been employed by you for less than one year state the number of weeks employed by you

If worker has not been employed by you for one year please provide the following information

Name of Employer		Dates Worked		
1.	from	/ /	to	/ /
2.	from	/ /	to	/ /
3.	from	/ /	to	/ /

Casual or Seasonal Worker

Total Earnings in past 12 months whilst employed with you $ If employed for less than 52 weeks the number of weeks employed by you

Declaration

IF PAYMENT IS RECOMMENDED PLEASE SIGN THIS FORM. IF NOT, PLEASE SIGN AND ATTACH A STATEMENT PROVIDING REASONS

Having made independent investigation into this claim, I certify that the above particulars are correct, and recommend payment of compensation.

Employers signature Date / /

Name and position of signee

Name of Rehabilitation contact

*Important – the worker must supply a written explanation accounting for any delay in reporting the occurrence or attending for treatment of his/her disability.

NO COMPENSATION IS TO BE PAID UNTIL AUTHORITY FROM QBE HAS BEEN OBTAINED.