

# WORKERS' COMPENSATION EMPLOYER'S REPORT



You must lodge this form with Allianz within **five working days** of being notified of an injured person's claim.

## 1 Employer Details

Legal Entity / Name

Trading Name

ABN Number

ITC % Entitlement

 %

Address

  
Postcode:

Postal Address

  
Postcode:

Telephone

( )

Fax Number

( )

E-mail Address

Main Business or Industrial Activity

Policy Number

Due Date

 / /

Risk Number

## 2 Claimant Details

Name

Physical Address

  
Postcode:

Email Address

Home Telephone

 ( )

Mobile Number

Place Of Birth

Date Of Birth

 / /

If Claimant has difficulty understanding English, what is their preferred language?

Relationship to Employer (if any)?

Occupation (including Industrial Award designation).

Marital Status

No. Dependant Children (under 16 years)

Is Spouse working?

No

☐

Yes

☐

How long has the Claimant been in your employment?

Is the Claimant on a Visa? No ☐ Yes ☐

If Yes, what type of Visa is the Claimant on?  
e.g. 457 working holiday

When does the Visa expire?

 / /

At the time of the occurrence was the Claimant working as a:

Direct Employee? ☐

Working Director? ☐

Contractor? ☐

Employee of Contractor? ☐

Sub-Contractor? ☐

If Yes, give name and address of Contractor or Sub-Contractor?

Name

Address

  
Postcode:

Does Claimant employ labour?

No

☐

Yes

☐

Other? ☐

Describe the actual tasks carried out by the Claimant.



## 5 Accident Description

What was the Claimant doing when the accident happened?

What caused the accident?

Were vehicles involved in the accident?

No ☐ Yes ☐

If Yes, complete claim form for Injury on the Journey.

Was any other object, machinery, footwear, clothing or other item involved in the accident? If so, please provide details.

### Retain any such objects or items.

Describe the nature and extent of the injury.

Has the Claimant ever had a similar injury?

No ☐ Yes ☐

If Yes, give details.

Did the Claimant have any pre-existing condition, including any injury, disease or illness prior to the accident?

No ☐ Yes ☐

If Yes, give details.

Did any third parties cause or contribute to the accident?

No ☐ Yes ☐

If Yes, please provide contact details.

If so, were there any contracts in existence between the employer and any such third parties?

No ☐ Yes ☐

## 6 Reporting

Date Accident Reported

Time

 am/pm

Name of person to whom the accident was reported.

Position

Date claim documents were given to the Employer by the Worker.

## 7 Other Benefits

Is the Claimant entitled to receive any allowance, benefit or compensation for this injury from any other source?

No ☐ Yes ☐

If Yes, give details.

## 8 Witnesses

Name

Name

## 9 Important

You must attach full details if:

- The claimant violated any statutory (or other) regulation at the time of the accident.
- There was any misconduct by the claimant (or any other party) that contributed to the accident.
- There are any special circumstances about which Allianz should be told.

## 10 Declaration

I declare the answers give on this form are true and correct.

Signature

Date

Print Name

## 11 Employer Notice

- \* Failure to lodge this form with Allianz within 5 working days of claim notification may result in you being penalised 3 days compensation.
- \* Attach employee's report and medical certificates to this form.
- \* **Do not commence paying compensation until advised to do so by Allianz.**

Please return to:

**Allianz Australia Insurance Limited**  
**PO Box K772**  
**Perth WA 6842**

**Fax: 1300 662 439 or (08) 9422 8650**

**Email: WAWC.Claims@allianz.com.au**

## BOX A

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Other \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						

\$  State base weekly or hourly award rate.

State award name and classification.

Please supply documentary proof.

## BOX B

\$  Total Gross Earnings

Dates employed if NOT full 52 weeks:

From

/  /

to

/  /

Please supply a detailed weekly summary of wages paid for this period.

# RATE OF PAY CALCULATION (SHEET 1)

## Schedule 1 Clause 11

CLAIM NUMBER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORKER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

**AMOUNT A – WORKER EMPLOYED PURSUANT** to an Industrial Award, Workplace Agreement or Agreed Contract.

\*COPY OF EMPLOYMENT CONTRACT ATTACHED ☐ YES ☐ NO

### **PART 1 – Clause 11(2) - Calculation for the First 13 Weeks**

Capped at the maximum weekly amount

**= The average of the overtime, over award, service payments, bonus or allowances for the 13 weeks prior to the date of incapacity + the award rate**

**OR**

If the worker was employed for less than 13 weeks (or any weeks which included time lost due to sick or annual leave) then averaged over that lesser period.

Week	Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Regular Over Award or Service Payments \$	Total \$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
Total						

= \$ \_\_\_\_\_ Gross Per Week

### **PART 2 – Clause 11(3)(b) – Calculation for Week 14 and Ongoing**

Capped at the maximum weekly amount

The rate of weekly earnings under the relevant Award or Agreement, plus any over award or service payments made on a regular basis plus any allowance paid on a regular basis as part of the worker's earnings and relating to the number or pattern of hours worked, but EXCLUDING overtime, other allowances and bonuses, up to the maximum weekly capped amount.

= \$ \_\_\_\_\_ Gross Per Week

# RATE OF PAY CALCULATION (SHEET 2)

## Schedule 1 Clause 11

CLAIM NUMBER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORKER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

**AMOUNT B – SUB CONTRACTOR OR WORKER EMPLOYED** on a rate per hour, or as per contract (written or verbal) with the insured or any agreement not certified with the Industrial Relations Commission.

**NB: This does not include casual or seasonal workers under Clause 14.**

\*COPY OF SUB CONTRACTOR LETTER OR CONTRACT ATTACHED ☐ YES ☐ NO

\*DETAILS OF VERBAL AGREEMENT ARE:

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\*PLEASE ATTACH A COPY OF 52 weeks Gross Earnings (inclusive of overtime and any bonus or allowances) PRIOR TO THE DATE OF INJURY.

### **PART 1 – Clause 11(2) - Calculation for the First 13 Weeks**

Capped at the maximum weekly amount

Divide the gross amount by 52 weeks.

OR

If the worker was in more than one employment at the end of that period, the sum of the average weekly gross earnings in each employment, divided by the lesser period.

OR

If the worker has been in an employment for a period of less than one year, the worker's average weekly earnings in that employment is to be determined over the lesser period.

= \$\_\_\_\_\_ Gross Per Week

### **PART 2 – Clause 11(4)(b) – Calculation for Week 14 and Ongoing**

Capped at the maximum weekly amount

= 85% of **Amount B**

= \$\_\_\_\_\_ Gross Per Week