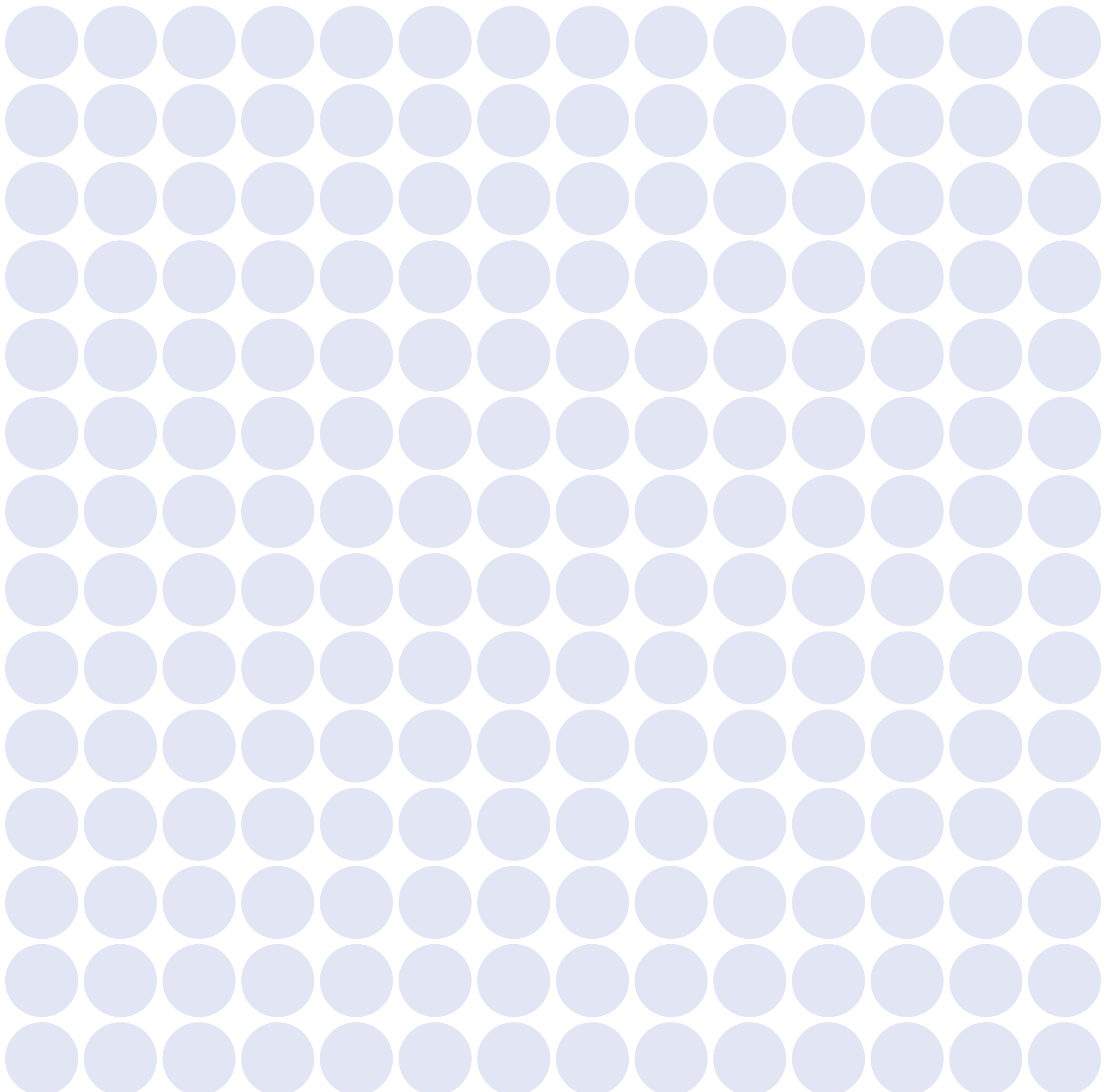
ZURICH

Employee's Compensation

Claim Form



Employee's Compensation

ZURICH®

Claim Form

Claim No.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). We collect, use, process and store Personal Information and, in some cases, Sensitive Information such as health information, about you in order to comply with our legal obligations and in order to assess your claim and administer the policy ('purposes').

By providing us or your intermediary with your Information, you consent to our use of this Information and where relevant for the purposes, you consent to our disclosure of your Personal Information, including your Sensitive Information, to your intermediary, the policy owner and their representatives, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers (including assessors), our business partners, medical and health practitioners, government offices and agencies, regulators, law enforcement bodies and as required by law within Australia or overseas. These laws include the Anti-Money Laundering and Counter-Terrorism Financing Act 2006, Personal Property Securities Act 2009, Corporations Act 2001, Insurance Contracts Act 1984, Autonomous Sanctions Act 2011, Income Tax Assessment Act 1997, Income Tax Assessment Act 1936, Income Tax Regulations 1936, Tax Administration Act 1953, Tax Administration Regulations 1976, A new Tax System (Goods and Services Tax) Act 1999 and the Australian Securities and Investments Commission Act 2001 as those laws are amended, and includes any associated regulations. From time to time other acts may require, or authorise us to collect your personal information.

If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim.

Zurich may obtain Information from government offices, the parties listed above and third parties to administer policies and assess a claim in the event of loss or damage.

In most cases, on request, we will give you access to personal information held about you.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or to make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687 or email us at Privacy.Officer@zurich.com.au

To (full name of employer)

Whilst in your employ I sustained the injury described below and I elect to claim under the provisions of the ACT Workers Compensation Act 1951.

1 About you, the worker

Surname First names

Home address Postcode

Phone number Sex: Male ◯ Female ◯ Date of birth / /

Occupation and trade qualifications

Married (including de facto) ◯ Not married ◯ Country of birth

Language spoken at home Interpreter required? Yes ◯ No ◯

2 Dependants (eg. wife, husband, children, parents, de facto)

Is spouse of de facto working? Yes ◯ No ◯

Full name of dependant	Relationship to worker	Date of birth	Full time student (Yes or No)	Resident at home (Yes or No)

ZU1029 - V4 03/14 - CGEL-007894-2013

Zurich Australian Insurance Limited ABN 13 000 296 640, AFS Licence No. 232507.
Canberra Office: Ground Floor, 99 Northbourne Avenue Turner ACT 2612. GPO Box 801 Canberra ACT 2601.
Phone (02) 6247 3766, Fax 1800 074 778.

3 Other current employers

Do you have any other employment? Yes ◯ No ◯ If 'Yes', give details

Full name of employer

Address Postcode

4 What happened?

How did the accident occur, and what were you doing at the time? (eg. slipped while climbing a ladder)

Names and address of any witnesses

First name	Surname	Street address	Suburb

5 Injury details

Date of injury / / Time of injury ◯ am ◯ pm Date notice given / /

Time notice given ◯ am ◯ pm To whom was the accident reported?

If you stopped work due to the injury – Date stopped / / Time ◯ am ◯ pm

Place and address where injury occurred (eg. machine shop)

What injury(ies) did you suffer? (eg. fracture)

What parts of body were affected? (eg. left upperarm, lower back)

Was the part normal before the accident? Yes ◯ No ◯ If No, give details

Name of treating doctor (if applicable)

Name of hospital (if applicable)

WorkSafe Medical certificate attached Yes ◯ No ◯

6 Other similar injuries

Have you previously suffered similar related injuries or conditions Yes ◯ No ◯ If 'Yes', give details of how injury occurred

Name of employer (if applicable)

Date of injury(ies) / /

Nature of injury(ies)

7 Journey injuries

A separate **'Injury on the Journey'** Claim Form must be completed in addition to this Claim Form.

8 Declaration

It is an offence under the ACT Workers Compensation Act 1951 to make false and misleading statements.

I, ... hereby declare the truth of the foregoing statement and I understand that while I am in receipt of weekly payments of compensation I am obliged to forthwith notify the insurer of:

(a) my commencing employment with some other person; or

(b) my commencing my own business; or

(c) any change in my employment that affects my earning.

I am aware that it is an offence to fail to do so.

I hereby authorise any medical practitioner or other authority to provide the insurer with any and all information regarding my medical and/or factual history in respect of injury on / /

A photocopy of this authority shall be as valid as the original. I also hereby consent to the disclosure of any medical and/or factual information in respect of this injury to such person or persons as considered appropriate in connection with the claim.

Signature of worker	Date
✗	/ /

Signature of witness	Date
✗	/ /

A postmaster or person in charge of a post office, a magistrate, a justice of the peace, a barrister or solicitor, a school head-teacher, a member of the police force, a medical practitioner, a notary public, a commissioner for declarations, a minister of religion, or a Member of the Legislative Assembly or the Parliament.

9 To be completed by the Employer

Signature of employer	Date
✗	/ /

Date claim received / /

Notes to injured worker

1. This form should be completed as soon as possible after receiving a work-related injury and given immediately to your employer.
2. Complete all questions fully and accurately, errors and omissions may delay payment of benefits or result in the claim being disputed.