ZURICH

Recurrence / Aggravation of Injury

TO BE COMPLETED WHERE A WORKER HAS LOST FURTHER TIME FOLLOWING A RETURN TO WORK OR WHERE THERE HAS BEEN A RENEWAL OF TREATMENT OF THE ORIGINAL INJURY.

ATTACH MEDICAL CERTIFICATE AND REPORTS IF AVAILABLE.

CLAIM NO. (Office use only) | PPS Yes ☐ No ☐

Privacy statement and consent

Zurich is bound by the *Privacy Act 1988* (Cth). We collect, disclose and handle information, and in some cases personal or sensitive (e.g. health) information, about you ('your details') to manage and investigate claims, administer policies, comply with our legal obligations, contact you and enhance our products and services ('Purposes'). If you do not provide your information, we may not be able to do those things. By providing us, our representatives or your intermediary with information, you consent to us using, disclosing to third parties and collecting from third parties your details for the Purposes.

We may disclose your details, including your sensitive information, to relevant third parties including your intermediary, policy owners, affiliates of Zurich Insurance Group Ltd, insurers, reinsurers, our service providers, our business partners, health practitioners, your employer, parties affected by claims, government bodies, regulators, law enforcement bodies and as required by law, within Australia and overseas.

We may obtain your details from relevant third parties, including those listed above. Before giving us information about another person, please give them a copy of this document. Laws authorising or requiring us to collect information include the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (Cth), *Workers Compensation and Injury Management Act 2023* (WA), *Autonomous Sanctions Act 2011* (Cth), *A New Tax System (Goods and Services Tax) Act 1999* (Cth) and other financial services, crime prevention, trade sanctions and tax laws.

Zurich's Privacy Policy, available at www.zurich.com.au or by telephoning us on 132 687, provides further information and lists service providers, business partners and countries in which recipients of your details are likely to be located. It also sets out how we handle complaints and how you can access or correct your details or make a complaint.

1 Worker

Surname | Other Names

Address | Postcode

Current Employer | Claim No. (if known)

Employer at time of original injury

Nature of injury

Date of original injury / / | Date of further period of incapacity / /

Date of return to work / /

2 Recurrence / Aggravation details

1. (a) Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred

(b) If a further incident occurred, please provide details of this further incident

ZU22918 - V 05/24 - SILC-022116-2024

2 Recurrence / Aggravation details (continued)

2. Were there any witnesses to the onset of further symptoms? Yes ☐ No ☐

   If 'Yes', provide names and address, and attach statements

3. Was the onset of symptoms reported? Yes ☐ No ☐ If 'Yes', when? / /

   and to whom?

4. (a) State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms

   (b) What medical treatment have you been receiving prior to the latest onset of symptoms?

   State the names of treating Doctors and dates of treatment

5. Give full details of your employment between the date of the original injury and the recurrence / aggravation.

   Supply names of all Employers, dates worked and Occupation

3 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 take notice that under the *Workers Compensation and Injury Management Act 2023* (WA), I am required to notify my employer or insurer within 7 days if I commence paid work with another employer after making a claim, or while receiving income compensation.

I hereby authorise any Doctor to divulge to my Employer, or their Insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regards to myself.

Dated this day of 20

Signature of Worker Date

✗ / /

Signature of Witness Date

✗ / /

Save File Print Form