allinsure

CLAIM FORM
Workers Compensation

Please answer all questions in full, using the spaces provided as well as additional pages as required.

Employer Information

Name (as per policy)

Address

Policy Number

Employer ABN

Employer Contact

Phone Number

Fax Number

Mobile

Injured Worker Information

Surname

First Name

Occupation

Male or Female

Date of Birth

D D / M M / Y Y

Address

Phone Number

Mobile

Email

info@allinsure.com.au

Date of Injury

D D / M M / Y Y

Time of Injury

Date Employer was notified

D D / M M / Y Y

Type of injury/disease suffered (e.g. fracture, strain etc.)

Part of body injured (e.g. lower back, right arm etc.)

Describe how the injury occurred/cause of injury

Address where accident occurred

Has the worker lost any time from work?

☐ Yes ☐ No

Date Ceased

D D / M M / Y Y

Date Resumed

D D / M M / Y Y

Was first aid treatment provided?

☐ Yes ☐ No

Name of person providing first aid

Was the accident witnessed?

☐ Yes ☐ No

Name of Witness

Position Held

Phone Number

Fax Number

Mobile

info@allinsure.com.au

Treating Doctor Information

Name of Medical Practice

Name of Doctor

Address of Medical Practice/Doctor

Phone Number

Fax Number

Signature

Name of person reporting/registering injury details

Employer Signature

Date

D D / M M / Y Y

Workers Declaration and Consent

I declare that the above information is correct and hereby authorise any medical practitioner or treatment provider to provide my workers compensation insurer or my employer with any medical information in relation to this injury.

Workers Signature

Date

D D / M M / Y Y

Note: Employer must add the details of the injury/disease on the injury register as required under Section 92 of the *Workers Compensation Act 1951* (ACT) No. 2.

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