Willis Temby
Insurance Brokers (WA) Pty Ltd
Registered Insurance Brokers
AFSL No. 233 765

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EXECUTIVE DIRECTOR

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EXECUTIVE DIRECTOR

WORKERS COMPENSATION EMPLOYERS REPORT

EMPLOYER DETAILS

Policy Number (From your schedule)

Expiry Date

Insured (Surname, Company, Partnership, Occupation)

Given Name(s) of the Insured

Contact Person (for the company or partnership)

Number of Employees Engaged in the business

Total Weekly Payroll

Are you registered for GST Purposes?

No ☐ **Yes** ☐ **What is your ABN?**

Have you claimed or do you intend to claim an input tax credit on the GST applicable to this policy?

No ☐ **Yes** ☐ **Percentage Claimable**

Address

Contact Number(s)

INJURED EMPLOYEE DETAILS

Surname

Given Names

Date of Birth

Address

Industry in which Employed

Occupation

Date Employed

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

Steadfast

NIBA
National Insurance Brokers Association

If in your direct employ, for how many 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 the 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

ACCIDENT DETAILS

Day of week Date Time

Exact Place or Location where injury was sustained

Did the injured person give notice of injury Yes ☐ To Whom?

Verbally ☐ In Writing ☐

No ☐

Name of Witness to the accident, persons in the vicinity or aware of the accident (witness statements to be attached)

Give full details of how the 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 address of those concerned and the name and address of their employer

Has the worker discontinued their duties? Yes ☐ No ☐

Has the worker returned to work? Yes ☐ No ☐

What is the estimated time of absence from work?

Is compensation being claimed for any other source? **Yes** ☐ **No** ☐

If yes, please specify

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

AFTER READING CAREFULLY THE EXPLANATORY NOTES BELOW PLEASE COMPLETE THE SCHEDULE – PLEASE COMPLETE SECTION A, B OR C

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**.**

A – AWARD WORKERS

Name of Award or Agreement under which worker is paid

Workers Job Classification under that award

Regular Over Award Payments **(provide details of payment types e.g. Overtime, bonus etc)**

Total Earnings for the 13 weeks immediately prior to the date of injury

B – NON AWARD WORKERS

Total earnings for the 52 weeks immediately prior to the date in injury

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

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

Name of Employer	Dates Worked

C - CASUAL OR SEASONAL WORKER

Total earnings in the past 12 months whilst employed with you	
If employed less than 52 weeks, the number of weeks employed by you	

DECLARATION

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

Signature of Insured or person with authority to sign For and on behalf of a company or partnership	Date

PLEASE NOTE: NO COMPENSATION WILL BE PAID UNTILL AUTHORITY FROM THE INSURER HAS BEEN OBTAINED