

First contact notification

(Workers Compensation excluding QLD, SA & VIC)

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545



NOTE: You will also need to complete a claim form and submit it to QBE if this notification is likely to give rise to a claim for compensation. Claim forms are [available on our website](#). For assistance please call: +61 2 9375 4444 or see the [Help section](#) on our website. Email form to: mywccclaim@qbe.com, or use the 'Submit Form' button.

Please fill out the form below as complete as possible.

Injured worker details

	First name	Last name		
Name* (Block letters)				
Gender*	Male	Female	Date of birth*	
Postal address*				
		State	Postcode	
Occupation*				
	Home number*		Work number	
	Mobile		Email	
Worker's average earnings (last 12 months)*				
	Award rate		Preferred language	
Currently off work*	Yes	Do you expect more than 5 working days off for this injury?*	Yes	No
	No		Notification only (no lost time or medical costs)	

Employer details

Business name*		QBE policy number*	
	Phone number*	Mobile	
	Fax	Email	
Business address*			
		State	Postcode
Contact name			
	Contact number	Cost centre	
Wages to be reimbursed via wage reimbursement schedule?*	Yes	No	

Medical and injury details

Date of injury*		Date notified employer*		Time of injury*	
Address of injury*					
		State	Postcode		
How did the injury occur?*					
Worker's condition*					
Part(s) of body affected?*					
Date of first medical treatment		Time of treatment			
Doctor / Hospital					
		State	Postcode		

Person making notification

First name		Last name	
Contact number		Relationship	

Note: You will be prompted to complete mandatory fields (highlighted in red) and confirm the sender details when you click on the 'Submit Form' button.