# Allianz (II

Agent for the NSW WorkCover Scheme

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**Claimant Name** 

WorkCover

Date of Injury

# WORKERS COMPENSATION ACT 1987 OTHER WORK RELATED INJURIES CLAIM FORM

This supplementary information is to be provided by:

- a) A worker in respect of:
  - an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment, or between the place of abode and any trade, technical or other training school, where there is a real and substantial connection between the employment and the accident an injury received while on a journey between the worker's place of abode and other places referred to in section 10 (3) (c) (g) of the *Workers Compensation Act* 1987, where there is a real and substantial connection between the employment and the accident

Claim no.

- an injury received while on a journey between the worker's place of employment and other places referred to in section 10 (3) (c) (g) of the Workers Compensation Act 1987
- an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment.
  b) Those parties exempt from the 2012 legislation changes (police officers, paramedics, firefighters, coalminers, emergency service workers and rescue association workers) in respect of:

   an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment or to any trade, technical or other training school, or otherwise in the course of their employment

  - an injury received while on a journey between the worker's place of abode or place of employment and other places referred to in section 10 (3) [c] [g] of the Workers Compensation Act 1987

an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment. e complete this form in BLOCK letters and use a black pen.

| ľ | f further s | pace is | required. | attach a | separate | page. |
|---|-------------|---------|-----------|----------|----------|-------|

| Please indicate in which State you want to lodge this claim: | Where exactly did the accident occur? eg. street  |
|--|---|
| New South Wales Queensland Victoria                          | Suburb Postcode   |
| 1 WORKER'S DETAILS   | Suburb Postcode   |
| Family name  |   |
|  | Where were you travelling to? – eg. work, home, technical school                            |
| Given names  |   |
|  | Where were you travelling from? – eg. work, home, technical school                          |
| Date of birth Sex  | Did the accident involve a motor vehicle<br>whilst you were working? Yes No                 |
|  | technical school?   |
| Suburb Postcode  | Were you on a recess or authorised break? Yes No  |
|  | What was the purpose of your journey?   |
| Phone Mobile   |   |
|  |   |
| Employer's name  | What is your usual route for this journey?  |
|  |   |
|  |   |
| Address  |   |
| Address  |   |
|  | Did you divert from your usual route?    Yes    No      If Yes, provide details    No    No |
| Suburb Postcode  |   |
|  |   |
| Phone Fax  |   |
|  |   |
| Email  | Was there any interruption to the journey for any reason?                                   |
|  | Yes No If Yes, provide details  |
|  |   |
| 2 JOURNEY DETAILS  |   |
| Date and time of accident                                    |   |
| Date / /   | Had you consumed any alcohol or drugs in the 12 hours                                       |
| What mode of transport were you using?                       | immediately prior to the accident? Yes No<br>If Yes, how much?                              |
| eg. motor vehicle, public transport, walking, other          |   |

| Claim no. |  |
|-----------|--|
|           |  |

How did the accident occur? Please provide a detailed description.

| <br> |
|------|
|      |
|      |
|      |
|      |
|      |

#### Contact details of witnesses

| Full name | Address | Phone number |  |  |  |  |
|-----------|---------|--------------|--|--|--|--|
|           |         |              |  |  |  |  |
|           |         |              |  |  |  |  |
|           |         |              |  |  |  |  |
|           |         |              |  |  |  |  |

#### In your opinion, who was responsible for the accident? Why?

# **3 TRAFFIC ACCIDENT DETAILS**

All traffic accidents in which someone is injured, must be reported to the police as soon as possible but no later than 28 days after the accident. If you have not reported your accident, you should do so immediately.

#### A. IF YOU WERE INJURED IN A TRAFFIC ACCIDENT

Police station to which the accident was reported

ſ

| Date / / / /          |   |
|-----------------------|---|
| Police officer's name |   |
|                       | ] |
|                       |   |

| Did police attend the accident? Yes No                       |
|--|
| Police reference number                                      |
| Police action taken or proposed                              |
|  |
|  |
|  |
| If you were a driver/passenger, were you wearing a seatbelt? |
|  |

| Yes   |      | NO        |      |                                      |
|-------|------|-----------|------|--------------------------------------|
| lf yo | u we | ere a rid | er/p | assenger, were you wearing a helmet? |
| Yes   |      | No        |      |                                      |

Using the symbols below, draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows the directions of travel.

| Your vehicle             |           |   |
|--------------------------|-----------|---|
| Other vehicle            | ightarrow | ► |
| Pedestrian , cyclist etc | ٥         | • |
| Intersection             | +         |   |

| Claim no. |  |  |  |  |
|-----------|--|--|--|--|
|           |  |  |  |  |

# **B. ABOUT THE VEHICLE IN WHICH YOU WERE INJURED**

| Registration number         | State of reg. |
|-----------------------------|---------------|
|                             |               |
| Driver's name               |               |
|                             |               |
| Driver's licence number     |               |
|                             |               |
| Residential address: Street |               |
|                             |               |
|                             |               |
| Suburb                      | Postcode      |
|                             |               |
| Phone: Work                 |               |
|                             |               |

# C. OTHER VEHICLES INVOLVED

| (if more than two vehicles, attach a separate list) |               |
|---|---------------|
| Registration number                                 | State of reg. |
|   |               |
| Driver's name                                       |               |
|   |               |
| Driver's licence number                             |               |
|   |               |
| Residential address: Street                         |               |
|   |               |
|   |               |
| Suburb Pos  | tcode         |
|   |               |
| Phone: Work   |               |
|   |               |

### **4 NON WORKERS COMPENSATION CLAIMS**

Have you made a personal injury claim other than a workers compensation claim regarding this accident?

No

Eg. a CTP claim or a public liability claim Yes

If Yes, provide details including the type of claim

| Name of insurer        |
|------------------------|
|                        |
| Claim/reference number |
|                        |

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

Phone: Mobile

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

#### **5 DECLARATION**

I have read the information provided in this form. I declare that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading statement in support of the claim is punishable by law and that I may be prosecuted.

I authorise and consent to any person who provides a medical or hospital service to me in connection with an injury/condition to which this claim relates to provide upon request by the workers' compensation authority, my employer or insurer/claims agent, any information regarding the service relevant to the claim. I understand that my authority has effect and cannot be revoked for the duration of this claim.

I authorise and consent to the collection, disclosure and release of any personal and health information in connection with an injury/condition to which this claim relates. I understand that if this claim results in me receiving weekly compensation payments, I am required to notify whomever is paying my benefits if I commence employment with some other person or in my own business, or of any change in my employment that affects my earnings, and that failure to do so is an offence. I consent to the WorkCover Authority of NSW using the information collected in connection with my claim for the purposes of research about workers compensation, workplace injury management and occupational health and safety.

Signature of injured worker

Date /

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