Workers' Compensation claim form

Use this form when making a claim for Workers' Compensation.

TOWER Insurance

Policyholder details

Personal details

First name(s)	
Last name	
Date of birth	d d m m y y y y

Contact details

Home phone			Work phone		
Facsimile			Mobile		
Email					

Postal address

Street address or Box number			
Suburb			
Town or city		Post code	

Date of injury or death

Date	d d m m y y y y
Time	h h m m ◯ a.m. ◯ p.m.

Important note

Issue of this form does not constitute an admission of TOWER Insurance's liability.

To be completed by the worker

Personal details

First name(s)	
Last name	
Date of birth	d d m m y y y y

Postal address

Street address or Box number			
Suburb			
Town or city		Post code	

Job description

Date of accident

Date	d d m m y y y y

Place of accident

Address	

When did you stop work?

Date	d d m m y y y y
Time	h h m m ◯ a.m. ◯ p.m.

When did you resume work?

Date	d d m m y y y y

What are your injuries?

What caused your injuries?

Are you married?

◯ Yes ◯ No

If yes, please state full name of spouse.

Details of marriage

Date of marriage	d d m m y y y y
Place of marriage	

Does your spouse live with you?

◯ Yes ◯ No

If no, please state where?

Is your spouse totally dependent upon you?

◯ Yes ◯ No

If no, how much?

Please list all dependents including children under 16 years of age

First person

Name	
Relationship to you	
Date of birth	d d m m y y y y
Place of residence	

Is the person totally dependent upon you? ◯ Yes ◯ No

If no, how much?

Second person

Name	
Relationship to you	
Date of birth	d d m m y y y y
Place of residence	

Is the person totally dependent upon you? ◯ Yes ◯ No

If no, how much?

Third person

Name	
Relationship to you	
Date of birth	d d m m y y y y
Place of residence	

Is the person totally dependent upon you? ◯ Yes ◯ No

If no, how much?

Fourth person

Name	
Relationship to you	
Date of birth	d d m m y y y y
Place of residence	

Is the person totally dependent upon you? ◯ Yes ◯ No

If no, how much?

Worker's declaration

- ◯ I hereby authorise any hospital, doctor, or other person who has given me medical attention, and my employer to give TOWER or its representatives, any and all information regarding any injury or sickness, medical history, or consultation I have previously had.
- ◯ I also authorise TOWER or its representatives to obtain full hospital records and employer records as required.
- ◯ I agree that a photocopy of this authority is as effective and valid as this original.
- ◯ And I declare that the information supplied in this claim form is a true and accurate statement with regard to my claim for compensation.
- ◯ I agree to advise my employer if any circumstances in regard to this claim, my dependants or my medical condition should change.

Signature

Signature of worker	
Date	d d m m y y y y

To be completed by the employer

Was the injured worker directly employed by you? ◯ Yes ◯ No

If no, state details of employment.

Average weekly earnings (including overtime)

Vt

Hours worked per day			Hours worked per week				Rate of pay per hour		

How long has the worker been employed by you?

Years			Months			Weeks		

Was the worker actually employed at the time of the accident? ◯ Yes ◯ No

Was the accident reported to you or the worker's supervisor at the time of occurrence? If no, when? ◯ Yes ◯ No

What was the worker doing at the time of the accident?

What was the cause of the accident?

What is the nature of their injuries?

Did the worker continue working after the accident? ◯ Yes ◯ No

If no, state the time the worker ceased work.

Date	d	d	m	m	y	y	y	y
Time	h	h	m	m	◯ a.m.	◯ p.m.		

In your opinion was the injury directly due to negligence? ◯ Yes ◯ No

If yes, state by whom and the nature of such negligence.

Was the injury due to the serious and wilful misconduct of the worker? ◯ Yes ◯ No

Was the worker sober at the time of the accident? ◯ Yes ◯ No

According to your records, what dependants does the worker have?

First person

Name										
Relationship to worker										
Date of birth	d	d	m	m	y	y	y	y		
Place of residence						Degree of dependency				

Second person

Name										
Relationship to worker										
Date of birth	d	d	m	m	y	y	y	y		
Place of residence						Degree of dependency				

Third person

Name										
Relationship to worker										
Date of birth	d	d	m	m	y	y	y	y		
Place of residence						Degree of dependency				

Fourth person

Name									
Relationship to worker									
Date of birth	d	d	m	m	y	y	y	y	
Place of residence						Degree of dependency			

Employer's declaration

☐ I/We declare that the information contained in this claim form is true and correct to the best of our/my knowledge.

Signature

Signature of employer								
Date	d	d	m	m	y	y	y	y

OFFICE USE ONLY

Client number								
Claim number								