



Claim Form

ACT Workers Compensation Employee's Claim Form



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Employer's Policy Number:

Complete all questions fully and accurately, to ensure accurate decisions can be made about your claim

1. To (Full name of employer)

Whilst in your employ I sustained the injury described below and I elect to claim under the provisions of the ACT Workers' Compensation Act 1951 No. 2 as amended.

NOTES TO THE INJURED WORKER

1. You are required to tell your employer that you have received a workplace injury **as soon as possible** after being injured.
2. This claim form should then be completed and given immediately to your employer.
3. Complete all questions fully and accurately – errors and omissions may delay processing of your claim.
4. You are required to nominate a **'treating medical practitioner'**.
5. You are required to submit an **ACT WorkCover compliant medical certificate** with your claim.
6. The Workers' Compensation Act 1951 No. 2 emphasises workplace-based injury management, rehabilitation and return-to-work as quickly and as safely as possible. You are required to seek the cooperation of your treating medical practitioner in participating with GIO and your employer in developing your Personal Injury Plan for all significant injuries and in returning to some useful employment role as soon as possible.
7. **You must complete the Declaration in Part 7 and also The Release of Information Authority in Part 8 of this form.**

2. About the worker

Family Name		Given Name(s)	
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth	/ / Country of birth
Residential address			
			Postcode
Phone No	Fax	Email	
Language spoken at home		Interpreter required?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Your occupation		Commenced employment / /	
Employment with this employer: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Permanent <input type="checkbox"/> Casual <input type="checkbox"/>			

3. About your employer

Employer	
Employer postal address	
Postcode	
Phone No	Fax
Email	
Other current employment:	
Do you have a second job with another employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of second employer	
Contact name	Phone No
What is your average weekly earnings from this job? \$	
What are the average weekly hours in this job?	

3. About your employer *(continued)*

Previous employment (for last 5 years, most recent first)

1. Employer			
Date from	/ /	Date to / /	Position held
2. Employer			
Date from	/ /	Date to / /	Position held
3. Employer			
Date from	/ /	Date to / /	Position held
4. Employer			
Date from	/ /	Date to / /	Position held
5. Employer			
Date from	/ /	Date to / /	Position held

4.1 The injury

What happened? *How did the accident occur? Where were you? What were you doing at the time?*

Name and address of any witness

1. Surname	Given Name(s)
Residential address	
Postcode	Phone No
2. Surname	Given Name(s)
Residential address	
Postcode	Phone No

4.2 Injury details

During a break at work	<input type="checkbox"/>	Vehicle accident while working	<input type="checkbox"/>
Away from work during a recess	<input type="checkbox"/>	Journey to or from work and home	<input type="checkbox"/>
At work	<input type="checkbox"/>	Other	<input type="checkbox"/> e.g. <input type="text"/>
Date of injury	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time of injury	<input type="text"/> am/pm
Date notice given	<input type="text"/> / <input type="text"/> / <input type="text"/>	To whom was the accident reported?	<input type="text"/>
Time notice given	<input type="text"/> am/pm	If stopped work due to the injury	<input type="checkbox"/>
Date stopped	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time stopped	<input type="text"/> am/pm
Have you returned to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", date returned	<input type="text"/> / <input type="text"/> / <input type="text"/>
Time	<input type="text"/> am/pm	Place where injury occurred (e.g. machine shop, Civic Store, etc)	<input type="text"/>
What injury did you suffer (e.g. fracture/sprain/burn, etc)	<input type="text"/>		
Parts of body effected (e.g. left upper arm, right ankle, etc)	<input type="text"/>		
Was the part normal before the event?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "No", give details	<input type="text"/>
<input type="text"/>			
Name of hospital if treated at hospital	<input type="text"/>		
Treating doctor's name at hospital	<input type="text"/>		
Your nominated treating doctor's name	<input type="text"/>		
Practice address	<input type="text"/>		
Postcode	<input type="text"/>		
Phone No	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		
ACT WorkCover complaint medical certificate attached	Yes <input type="checkbox"/>	No	<input type="checkbox"/>

4.3 Other similar injuries

Have you previously suffered any similar related injuries or conditions	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
If "Yes", give details and include the dates and name/s of any previous employer, insurer and/or claim reference No:			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			

5. Traffic accident details

ONLY complete this Part 5 if you were involved in a 'Journey' to or from work, or a work related journey.

Complete only if the injury occurred away from your employer's premises or while you were on a journey to or from work.

Were you a	Pedestrian <input type="checkbox"/>	Driver <input type="checkbox"/>	Passenger <input type="checkbox"/>	Other	<input type="checkbox"/>
Where were you travelling from?	<input type="text"/>				
Where were you travelling to?	<input type="text"/>				
Date of accident	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time you left	<input type="text"/> am/pm		
Were you travelling	To work <input type="checkbox"/>	From work <input type="checkbox"/>	For work <input type="checkbox"/>	Other	<input type="checkbox"/> e.g. <input type="text"/>
If travelling to or from your place of work, had you followed your usual route	Yes <input type="checkbox"/>	No	<input type="checkbox"/>		
If "No", why did you divert from your normal route?	<input type="text"/>				
<input type="text"/>					
Was your journey broken for ANY reason	Yes <input type="checkbox"/>	No	<input type="checkbox"/>		
If "Yes", what was the "break" in your journey	<input type="text"/>				

5. Traffic accident details (*continued*)







1. Name	Registration Number
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Postcode

No

1. Surname	Given Name(s)
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Postcode	Phone No
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Your vehicle		Other vehicles	
Pedestrians		Cyclists	
Intersection		North Point	

6. Privacy statement

GIO General Limited is a Suncorp Metway company.

Suncorp Metway is an Allfinanz group offering many different categories of financial products and services in banking, insurance, investments, and advice on financial services.

We need to collect personal information from our customers so we can:

- set up and administer a product for the customer;
- determine a customer's requirements and provide the appropriate product or service;
- assess a claim made by a customer under one or more of our products;
- assess our customers and their needs;
- improve our financial products and services.

Without this information, we cannot provide the product or service.

Protecting the privacy of our customers is a key part of our normal operations.

As one of a number of companies that form the Suncorp Metway group, we provide personal information about a customer to all the related companies within this group. We do not disclose personal information to any outside third party organisation, unless it is contracted to Suncorp Metway to provide administrative services or activities on our behalf. In this case, we make sure that the third party is bound by the same privacy rules we follow.

Sometimes, Suncorp Metway might use personal information to make product related material on a range of financial products and services available to our customers. A customer may elect not to receive product related material or change their mind at any time about receiving product related material by calling 13 10 10.

A customer may access the personal information that we hold about them; get more information about Suncorp Metway; obtain a copy of our Privacy Policy, by calling 13 10 10, or contacting us at gio.com.au or by visiting any of our branches.

7. Declaration

(It is an offence under the ACT Workers' Compensation Act to make false and misleading statements.)

I, declare the truth of the statements made in this claim and understand that while I am in receipt of weekly payments of compensation I am obliged to immediately notify GIO of my commencing employment with some other person; or; my commencing my own business; if I commence any voluntary or unpaid work; or; any change in my employment that effects my earning. I am aware that it is an offence to fail to do so. By signing this form, I agree to GIO collecting, using and disclosing my personal information, including sensitive and health information if applicable, in accordance with the Privacy statement included in this document and the Suncorp Metway Privacy Policy.

Signature of injured worker

Date

/ /

Witness signature

Date

/ /

8. Release of information authority

I, authorise any medical practitioner or other authority to provide GIO with any and all information regarding my medical and/or factual history in respect to my injury on / / . A photocopy of this authority shall be as valid as the original. I also consent to the disclosure of any medical and/or factual information in respect of this injury to such person or persons considered by GIO as appropriate in connection with this claim.

Signature of injured worker

Date

/ /

Witness signature

Date

/ /

9. To be completed by employer

Signature of employer

Date

/ /

Date claim received from injured worker

/ /

The information in this document is confidential. It may contain privileged information. Disclosure of any particulars on this form to third parties may breach the Privacy Act 1988 (Cth) and is expressly prohibited by GIO General Limited without written approval by an authorised officer of GIO General Limited. GIO General Limited ABN 22 002 861 583.

GIO Workers' Compensation ACT Claims

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