



EMPLOYEE'S COMPENSATION CLAIM

CLAIM NUMBER

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 Workers Compensation Act of N.S.W.

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PLEASE PRINT IN BLOCK LETTERS

ABOUT THE WORKER

Surname _____		First names _____	
Residential address _____			Postcode _____
Telephone No. _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth _____	
Occupation and trade qualifications _____			
Married (including de facto) <input type="checkbox"/>	Not married <input type="checkbox"/>	Country of birth _____	
Language spoken at home _____	Interpreter required	YES <input type="checkbox"/>	NO <input type="checkbox"/>

DEPENDANTS

Is spouse or de facto working? _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
Full name of dependant _____	Relationship to worker _____	Date of birth _____	Full time student (yes or no) _____	Residing at home (yes or no) _____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OTHER CURRENT EMPLOYERS

Do you have any other employment? _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES, give details _____
Full name of employer _____			
Address _____			

WHAT HAPPENED? How did the accident occur, and what were you doing at the time? (e.g. Slipped while climbing a ladder)

Name and address of witness _____

INJURY DETAILS

Date of injury _____	Time of injury _____	am/pm _____	Date notice given _____
Time notice given _____	am/pm _____	To whom was the accident reported _____	
If you stopped work due to the injury – Date stopped _____		Time _____	am/pm _____
Address and place where injury occurred (e.g. machine shop) _____			
What injury(ies) did you suffer? (e.g. fracture) _____			
What parts of body were affected? (e.g. left upper arm, lower back) _____			
Was the part normal before the accident? _____		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If NO, give details _____			
Name of hospital (if applicable) _____			
Name of treating doctor (if applicable) _____		Workcover Medical Certificate attached YES <input type="checkbox"/> NO <input type="checkbox"/>	

OTHER SIMILAR INJURIES

Have you previously suffered any similar related injuries or conditions? YES NO

If YES give details of how injury occurred

Name of employer (if applicable)

Date of injury(ies)

JOURNEY INJURIES – A separate “Injury on the Journey” claim form must be completed in addition to this claim form

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.

DECLARATION *(It is an offence under Section 92B of the Workers Compensation Act to make false and misleading statements)*

I, _____ declare the truth of the above statements and I understand that while I am in receipt of weekly payments of compensation I am obliged to immediately notify GIO of:

- (a) my commencing employment with some other person; or
- (b) my commencing my own business; or
- (c) any change in my employment that affects my earning.

I am aware that it is an offence to fail to do so.

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 of 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 as considered appropriate in connection with the claim.

By signing this claim 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 _____ Date _____

TO BE COMPLETED BY THE EMPLOYER

Signature of Employer _____ Date _____

Date Claim Received _____

NOTES TO THE INJURED WORKER

1. This form should be completed as soon as possible after receiving a work related injury and given immediately to your employer.
2. Complete all questions fully and accurately, errors and omissions may delay payment of benefits or result in the claim being disputed.
3. To ensure prompt consideration for payment of benefits on this claim, you should attach a medical certificate as prescribed by the Act.
4. Workcover places a major emphasis on workplace-based rehabilitation, that is, the return to work as quickly and as safely as possible. You are required to seek the co-operation of your treating medical practitioner in returning to some useful employment role as soon as possible by asking for a medical certificate, as prescribed by the Act, noting restrictions and likely rehabilitation requirements.

