

Submit by phone 08 9264 2222 fax 08 9264 2292 or
email earlynotification.wa@cgu.com.au

Employer's information

Name of employer		Policy no.
<input type="text"/>		<input type="text"/>
ABN	Address	
<input type="text"/>	<input type="text"/>	
		Postcode
<input type="text"/>		<input type="text"/>
Contact person	Division	
<input type="text"/>	<input type="text"/>	
Telephone no.	Facsimile	Cost centre/Dept code
(<input type="text"/>)	(<input type="text"/>)	<input type="text"/>

Worker's information

Mr Mrs Miss Ms

Surname	First name	
<input type="text"/>	<input type="text"/>	
Address		
<input type="text"/>		
Postcode		
Telephone no.	Mobile	Occupation
(<input type="text"/>)	<input type="text"/>	<input type="text"/>
Date of birth		
<input type="text"/>		

Injury or illness and accident details

Date of injury	Time of injury	Date notice given	Time notice given	
<input type="text"/>	<input type="text"/> am/pm	<input type="text"/>	<input type="text"/> am/pm	
Date ceased work	Time ceased work	Date resumed work	Time resumed work	Time lost?
<input type="text"/>	<input type="text"/> am/pm	<input type="text"/>	<input type="text"/> am/pm	No <input type="checkbox"/> Yes <input type="checkbox"/>
Describe how the injury happened				
<input type="text"/>				
<input type="text"/>				
Describe the worker's injury or condition (e.g. laceration, dermatitis)				
<input type="text"/>				
Address where incident occurred				
<input type="text"/>				

Is the incident likely to become a claim? No Yes

Is employee currently:

- At work, performing normal duties
- At work, normal hours, performing suitable duties
- At work, on reduced hours
- Off work

Circumstances of injury:

- Whilst at work
- Travelling to or from work
- Away from work during a recess period

Injury details (cont'd)

Estimated duration of incapacity:

(includes either total or partial incapacity or a combination of both)

Seven or more calendar days estimated duration of incapacity.

(You must notify insurer within 48 hours) VERY IMPORTANT

For all other injuries, including medical expense only claims, or where the estimated duration of incapacity is less than seven calendar days.

(You must notify insurer within Seven days) VERY IMPORTANT

Treating doctor or hospital information

Name of treating doctor or name of hospital if hospitalised

Address of treating doctor or hospital

Postcode

Telephone no.

Facsimile

Notifier information

Person notifying us of the injury:

Worker Employer Other Please specify relationship to the worker or employer

Name of notifier, if other than worker or employer

Telephone no.

Address of notifier, if other than worker or employer

Postcode

Mode of notification eg mail, fax, email, internet