

Please print in block letters and answer all questions where applicable (provide full and complete answers). If a particular question does not apply, please write 'Nil' in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

The form should be completed and returned to CGU within 7 days of receipt by the insured.

To be completed where an injured person has been certified unfit following a return to work or where medical treatment of the original disability has been recommended.

Attach medical certificates and reports if available.

In order for your Employer or CGU to assess or otherwise deal with your claim we need to collect certain personal information. The information will be kept confidential and will only be used and disclosed for purposes related to assessing or otherwise dealing with your claim. Further details on our Privacy Charter and how we deal with personal information, including access to your information, is available from any CGU Insurance office or visit our website at [www.cgu.com.au/privacy](http://www.cgu.com.au/privacy).

## Injured person's details

Mr  Mrs  Miss  Ms

Surname

Given name(s)



Address

Postcode

Telephone no. / Mobile no.

Email address



Current employer

Contact person

Telephone no. / Mobile no.



Employer at the time of original disability

Contact person

Telephone no. / Mobile no.



Are you employed: directly?  as a contractor or sub-contractor?  by a contractor or sub-contractor?

Nature of disability

  


Date of original disability/injury

Date of recurrence

Date ceased work (if time lost)

 /  / 
 /  / 
 /  / 

Date of return to work (if time lost)

 /  / 

## Recurrence details

Were you performing usual work duties when the latest onset of symptoms or incapacity occurred?

Yes  What specific duties caused the recurrence?

  


No  Where were you and what were you doing?

## Recurrence details (continued)

Were there any witnesses to the onset of further symptoms? Please attach statements.

No

Yes  Please state:

Name

Address

 Postcode

Name

Address

 Postcode

Was the onset of further symptoms reported?

No

Yes  When?  /  /  To whom?

▶ What symptoms, if any, were you experiencing just prior to the latest onset?

  

▶ What medical treatment were you receiving prior to the latest onset of symptoms?

  

▶ Name of treating doctors

Dates of treatment

 /  /  /  /  /  / 

Have you changed employment since your original disability?

No

Yes  State names of employers, dates worked and occupation

  

## Declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true to the best of my knowledge and belief.

I take notice that under the provisions of Section 59(2) of the Worker's Compensation and Rehabilitation Act 1981 I am required to notify my Employer within 7 days should I commence work with another Employer after making this claim, or while receiving weekly payments of worker's compensation.

I consent to my Employer and CGU, in assessing or otherwise dealing with this claim, disclosing my personal information to or collecting my personal information from related entities of my Employer including my current employer, and CGU, other insurers, insurance reference bureaux, investigators, or other parties providing services to CGU.

I confirm that I am authorised to provide personal information about anyone else I have identified in this form.

Name of injured person

Name of witness

Signature

Date

 /  / 

Signature

Date

 /  / 

**Insurance Australia Limited** ABN 11 000 016 722 trading as CGU Workers Compensation.  
46 Colin Street West Perth WA 6005 GPO Box M929 Perth WA 6843  
Tel. (08) 9254 3600 Fax (08) 9264 2292 or (08) 9264 2286