RECURRENCE OF INJURY

This form is to be completed when you have experienced a recurrence of symptoms from a previous work-related injury. If there was a new incident that contributed to your current condition/injury, please contact us for further advice as you may not need to complete this form.

Please ensure you answer all questions in full, where applicable. If a particular question does not apply, please write N/A in the space provided. If additional space is required, please attach a separate sheet.

Please complete this form within 7 days and email it to workerscompclaims@iag.com.au or fax it to 1300 038 395. Please attach any supporting medical information such as medical certificates or any other reports.

Injured worker details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname

Given name(s)

Address

Postcode

Date of birth D D / M M / Y Y

Telephone No.

Email address

Original claim number

Date of original condition/injury D D / M M / Y Y

Employer at the time of original claim

Have you changed employment since your original disability/injury? No ☐ Yes ☐

If yes, please state the name of any employers (or self-employed), dates worked and your occupation

Please provide the contact details for your current employer (if this differs from original claim)

Contact person

Telephone no.

Recurrence details

Date of recurrence of symptoms D D / M M / Y Y

Please describe your current condition/injury?

Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred.

Were you experiencing any symptoms prior to this recurrence? If so, please confirm the nature of symptoms and any treatment undertaken since your recovery from the original injury.

Have you commenced any medical treatment since the recurrence of symptoms? If so, please confirm the date you commenced and details of this.

Please provide details of your treating doctors and allied health providers. Please include the clinic names and contact details to assist if we need to make any further enquiries.

Have you ceased work due to this recurrence? If so, please advise:

the date of incapacity : D D / M M / Y Y

the date you returned to work (if applicable) D D / M M / Y Y

Was the recurrence of symptoms reported?

No ☐ Yes ☐ When? To Whom?

Were there any witnesses to the onset of your recurrence of symptoms?

No ☐ Yes ☐ Please advise:

Name

Telephone No.

Contact details (postal address / email address)

Have you engaged in any other non-work-related activities that may have contributed to your recurrence of symptoms?

No ☐ Yes ☐ If Yes, please provide details

Declaration

I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge.

Name of Injured Worker;

Name of Witness;

Signature

Date D D / M M / Y Y

Signature

Date D D / M M / Y Y

Consent Authority

I authorise and give consent to CGU to access, view and receive details and/or documents which contain my personal, medical or any other information as may be necessary for, or relevant to their assessment of my workers' compensation claim.

This authority and consent extends to the collection, disclosure and release of any health and related personal information that is relevant to the injury or disease for which I have made a claim and includes information related to any prior claim, injury or disease, in any way relevant or related to my current claim. This includes the disclosure and release of such information to each other, and/or to one or more of the following: the relevant governing body of workers compensation legislation applicable to your claim, legal practitioner, medical practitioner, investigator, accredited vocational rehabilitation provider, or any other person reasonably consulted by the employer or insurer making a decision as to payment of the claim for compensation.

Any personal information you provide to us will be collected, stored, used and disclosed in accordance with our Privacy Policy located at www.cgu.com.au/privacy. Additionally, any sensitive information will only be used for the primary purpose for which it is collected. If you cannot access our Privacy Policy through our website, please contact us on 13 15 32 and we will send you a copy.

Name of Injured Worker;

Name of Witness;

Signature

Date D D / M M / Y Y

Signature

Date D D / M M / Y Y

Insurance Australia Limited
ABN 11 000 016 722
trading as CGU Workers Compensation