Employer's Indemnity Recurrence of Disability Claim Form

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.iag.com.au/privacy.

Injured person's details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname

Given name(s)

Address

Postcode

Telephone no.

( )

Current employer

Contact person

Telephone no.

( )

Employer at the time of original disability

Contact person

Telephone 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
	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 and CGU, other insurers, insurance reference bureaux, investigators, or other parties providing services to CGU.

Name of injured person		Name of witness	
Signature	**Date**	**Signature**	**Date**
	/ /		/ /