

# First contact notification

(Workers Compensation excluding QLD, SA & VIC)

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545



NOTE: You will also need to complete a claim form and submit it to QBE if this notification is likely to give rise to a claim for compensation. Claim forms are [available on our website](#). For assistance please call: +61 2 9375 4444 or see the [Help section](#) on our website. Email form to: [mywclaim@qbe.com](mailto:mywclaim@qbe.com), or use the 'Submit Form' button.

Please fill out the form below as complete as possible.

## Injured worker details

	First name		Last name		
Name* (Block letters)					
Gender*	Male	Female	Date of birth*		
Postal address*				State	Postcode
Occupation*					
Home number*			Work number		
Mobile			Email		
Worker's average earnings (last 12 months)*					
Award rate			Preferred language		
Currently off work*	Yes	Do you expect more than 5 working days off for this injury?*	Yes	No	Notification only (no lost time or medical costs)
	No				

## Employer details

Business name*			QBE policy number*		
Phone number*			Mobile		
Fax			Email		
Business address*				State	Postcode
Contact name					
Contact number			Cost centre		
Wages to be reimbursed via wage reimbursement schedule?*	Yes	No			

## Medical and injury details

Date of injury*	Date notified employer*	Time of injury*			
Address of injury*				State	Postcode
How did the injury occur?*					
Worker's condition*					
Part(s) of body affected?*					
Date of first medical treatment	Time of treatment				
Doctor / Hospital				State	Postcode

## Person making notification

First name			Last name		
Contact number			Relationship		

Note: You will be prompted to complete mandatory fields (highlighted in red) and confirm the sender details when you click on the 'Submit Form' button.