QBE Workers' Compensation Claim

QBE Pacific Islands

A. Notes

1. It is most important that all questions are answered. If not applicable, write "n/a".
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
4. Any amounts further marked as * are in the currency of the country in which the policy has been issued.
5. Markets

Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

MARKET	BUSINESS NAME	PLEASE TICK
Fiji	QBE Insurance (Fiji) Limited	
Papua New Guinea	QBE Insurance (PNG) Limited	
Solomon Islands	QBE Insurance (International) Pty Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

Note: For any other markets please contact the local QBE office.

6. Jurisdiction

The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:

a) the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless

b) the policy/ies refer to the laws of a different country applying, in which case the laws of that country,

and in relation to those matters, the parties submit to the exclusive jurisdiction of the courts of that country.

For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English law as applicable within Vanuatu immediately before 30 July 1980 and shall be exclusively justiciable before the Supreme Court of Vanuatu.

B. Employer details

Name of employer | **Business or profession**

Address

Tel no | **Fax no**

C. Accident details

1. Day of week | **Date** | **Time**

2. State exact place of locality where injury was sustained

3. Did the injured person give notice of injury? Yes No **To whom was it given?**

NOTE: If the worker failed to give notice of the injury as soon as practicable after its happening, he/she is required to supply a written signed statement containing his/her explanation, and showing reasonable cause why notice of injury was not so given.

a. When was it given - time? Date / / Verbally or in writing?

b. Give the names of person or persons who were actual eye witnesses of the injury.

It is necessary for the responsible person making this report to satisfy themselves that the information given herein is in accordance with the facts. The injured worker's own statement regarding injury is NOT acceptable without proper support.

4. Describe fully the circumstances leading to the accident.

5. What is the nature of injury?

6. If the injury was caused by any person or persons not in your employ please advise full name and address of those concerned.

D. Injured employee details

1. Name of injured person: Occupation

2. Address:

3. Industry in which employed How long in your employment

(e.g. farming, coal mining, clothing manufacture, road construction, flour milling)

4. State the operation at which the worker was engaged at the time of accident

5. a. Was injury sustained in the course of worker's employment with you? ☐ Yes ☐ No

b. Did injury arise out of worker's employment with you? ☐ Yes ☐ No

c. Was the worker in the service of any other employer at the time? ☐ Yes ☐ No

6. Was the worker injured while doing something which it was not part of their particular employment to do, or were they injured at a place or part of the works where they were not required to be by their particular employment?

7. Schedule

Age	Married or single	No. of days worked per week	Total earnings in your employ for previous 12 months (or part thereof) *	Average weekly earnings *	Is board and lodging provided in addition to weekly wages?	Date and time discontinued working	Length of time worked on day when injury occurred

8. Is the injured person related to you? If so, what is the relationship and does he or she reside with you? ☐ Yes ☐ No

9. State clearly if injured person is casual, permanent or working under contract.

E. Compensation details

1. a. Has the injured person returned to work? ☐ Yes ☐ No

b. If so, when?

2. Is compensation being claimed or received from any other source? If "Yes" please provide details. ☐ Yes ☐ No

3. Was the injured person free from physical infirmity at the time of the accident? ☐ Yes ☐ No

4. Are you aware whether the worker has ever previously suffered from a similar injury? ☐ Yes ☐ No

5. Was the part affected by this accident quite normal before the accident? If "No", please give full details. ☐ Yes ☐ No

6. Would such physical defect or infirmity have contributed towards this accident? If so, please give details. ☐ Yes ☐ No

7. If the worker has received any medical, surgical or hospital treatment, please state under which hospital and forward medical certificate if available.

a. Name of hospital

b. Whether in-patient or out-patient:

c. Name and address of doctor

8. Supplementary remarks as to anything affecting the cause or probable consequences of the injury. (If it is considered practicable to give an opinion, please state the approximate period of incapacity which it is expected will result from the injury).

9. Details of dependents (to be completed after consultation with employee).

Names	Date of birth	Relationship	State whether wholly or partially dependent

F. Notes

1. The company will require an explanatory report in the event of:

a. The injury being caused by any defect in works, ways, machinery, or plant;

b. The violation of any statutory or other regulations by the "worker" at the time of the injury;

c. Any serious and wilful misconduct on the part of the "worker" contributing to the injury;

d. The injury having been caused by the negligence of any person other than the employer.

2. Witnesses' statements, if procurable, should be obtained and forwarded, especially:

a. If doubt exists as to the circumstances under which a reported injury occurred;

b. In the event of hernia, sprains, strains, shock, jars and case where the injury is not apparent;

c. Where the injuries sustained are obviously serious.

Any change in the address of an injured worker is to be immediately notified to the company.

G. Signature and declaration

I/we declare that:

1. The information and answers given above are correct to the best of my/our knowledge and belief.
2. I/we understand the claim may be refused or reduced if information is withheld.
3. I/we hauthorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/we authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured	
Date	

Fiji

QBE Insurance (Fiji) Limited

QBE Centre, 33 Victoria Parade
Suva
Tel: + 679 331 5455
Fax: + 679 330 0285
email: info.fiji@qbe.com
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Papua New Guinea

QBE Insurance (PNG) Limited

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Solomon Islands

QBE Insurance (International) Pty Limited

Panatina Plaza, Prince Philip
Highway, Honiara
Tel: + 677 388 84
Fax: + 677 388 87
Email: info.sol@qbe.com
qbepacific.com

Vanuatu

QBE Insurance (Vanuatu) Limited

Level 2, Office 2a - 2c / 2g
Tana Russet Complex, Port Vila
Tel: + 678 353 00
Fax: + 678 355 10
Email: info.van@qbe.com
qbepacific.com

H. Medical certificate

To be completed by attending physician.

Are you still attending the insured person? ☐ Yes ☐ No

What are his/her present symptoms?

a. Totally disabled from / / **to** / / b. Partially disabled from / / **to** / /

If the insured person is still disabled, please state the probable date of their being able to resume a portion of their usual duties?

Date / /

How much longer is it probable the person's state of disability will continue? **days** **weeks** **years**

General remarks

I certify that to the best of my knowledge the foregoing statements are correct:

Name:

Address

Doctor's signature

Date