Insurance Commission of Western Australia

Government Insurance Division

Level 15, Tower 2
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Perth WA 6000
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Perth WA 6842
Tel: (08) 9264 3333
icwa.wa.gov.au

Personal Accident Claim

The Insurance Commission of Western Australia collects your personal information to assess and manage your claim. During the course of your personal accident claim, we will continue to collect other personal information from you and/or other relevant parties (including the insured government agency, hospitals, medical providers, etc.) for the same purpose. Your information may be shared with other authorised parties where necessary and authorised by law. For further details on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

1. Agency details

Agency name:	
Address:	
Contact name:	
Phone:	Email:
Risk/cost centre:	

2. Claimant details

Family name:	Given name(s):
Date of birth:	Gender: M ☐ F ☐
Address:	
Phone:	Email:

3. Employment details

Normal occupation:	Self-employed? Yes ☐ No ☐	Retired? Yes ☐ (when) No ☐
Name of employer:	Full time ☐ Part time ☐ Casual ☐ Hours per week:	
Address:		
Contact name:	Contact number:	
Contact email:		

4. Incident details

Has the incident previously been reported to us?	Yes ☐ If yes, please provide the claim number.	No ☐
Where did the incident occur?		
Date of incident:	Time: am/pm	
What was the capacity of the claimant?	Employee ☐ Volunteer ☐ If volunteer, please provide their duties at the time of injury:	
Date ceased paid work:	Date returned to paid work:	
Describe how the incident occurred:		
State the allegations made by the claimant (if known):		
Access type at incident location:	Restricted access ☐ Common user access ☐ General public access ☐	

5. Personal injury details (if applicable - attach any medical certificates or supporting documentation)

What actually happened and what caused the personal injury? What action was involved, e.g. – fall, caught between, struck by moving object:
What object/machine/substance was involved (if any), e.g. petrol fumes, wooden door frame:
Describe the most serious injury or disease caused by the occurrence, e.g. fracture, burn, cut, abrasion:
Describe the bodily location of the injury or disease, e.g. upper arm, ankle, eye:
Was the part of the body affected or injured by this occurrence healthy before the occurrence? Yes ☐ No ☐ If no, please provide details. Unknown ☐
Describe the physical location where the personal injury took place, e.g. playground:
How long has the person been confined to (if any):

Bed:	From:	To:
House:	From:	To:
Hospital:	From:	To:

Name of medical practitioner attending:
Address of medical practitioner attending:
Was the claimant admitted to hospital? Yes ☐ If yes, name of hospital: No ☐
Has the person required medical or surgical treatment during the past twelve months? Yes ☐ If yes, please provide details. No ☐ Unknown ☐
Is there any income protection insurance(s) covering this claim? Yes ☐ No ☐ Unknown ☐
If yes, provide insurance company and policy number:
Is the person a member of any government or private health insurance fund or scheme? Yes ☐ If yes, please provide details. No ☐

6. Work experience (if applicable)

At the time of the incident what school was the student attending?
Was the student participating in a school organised work experience program? Yes ☐ No ☐
Name of the host employer:
Address of the host employer:
What were the student's duties?
Did the student receive any wages for the work experience programme undertaken? Yes ☐ No ☐

7. School group activity students (if applicable)

At the time of the incident what school was the student attending?
Was the activity a part of an overnight excursion? Yes ☐ No ☐

8. Motor vehicle crash (if applicable)

Did the incident involve a motor vehicle crash?	Yes ☐	No ☐		
Was an online crash report form completed?	Yes ☐	If yes, please provide the receipt number:		No ☐
Make and model of vehicle:			Registration number:	
Name of insurer holding vehicle insurance:				
Street and locality where crash occurred:				
Who do you consider to have caused the incident and why?				
Are you the driver of the vehicle?	Yes ☐	No ☐	If no, please provide the driver's details.	
Driver's name:				
Driver's address:				
Driver's contact number:		Email:		

9. Witness details

Were there any witnesses?	Yes ☐	If yes, please provide details.	No ☐
Name:			
Address:			
Phone:		Email:	

10. Claimant declaration and authorisation

I declare that the details submitted are true and correct. I hereby authorise any doctor, hospital, clinic or other person to give the Insurance Commission any and all information concerning this claim. Further, I consent to the Insurance Commission and their appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my compensation claim, including determining liability. This consent extends to the Insurance Commission disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. NOTE failure to sign this consent may delay a decision by the insurer.

Signature: Date:

Name:	Position Title:
Phone:	Email:

11. Agency declaration and authorisation

I declare that the details submitted are true and correct and that I am the person authorised to lodge the claim with the Insurance Commission on behalf of the abovementioned agency.

Signature: Date:

Name:	Position Title:
Phone:	Email:

Please send the completed form and any relevant documents to sftnewclaims@icwa.wa.gov.au