Insurance Commission of Western Australia

Claim Number:

Employers Confirmation of Loss of Salary

1. Employee's Name

2. Date of Birth

3. Date of Crash

4. Name of Employer

5. Business Address

Telephone Number

6. Employee Details

Employee Number

Date employment commenced

Basis of employment

Casual ☐ Temporary ☐

Permanent ☐ Seasonal ☐

Is the employee employed on a contractual basis for a set period?

☐ ☐

Provide details of the contract.
If you require more space, use a blank sheet of paper and label your answer "Contract Details".

Date contract started

Date contract finishes

Is the employee an apprentice or a trainee? No ☐ Yes ☐

Type of apprenticeship or traineeship

Date commenced

Expected completion date

7. Employment Details

Has the employee had time off work because of any crash related injuries?

No ☐ Yes ☐

Have they returned to work?

No ☐

Expected return date (if known)

Yes ☐

Date on which they returned

Describe the employee's daily work duties – if available please attach a copy of the **Job Description**

Claim Number:

Is the work physical or non-physical?

Physical ☐ Non-physical ☐

Are alternative duties available (e.g light duties, modified duties etc)?

No ☐

Yes, provide details

Provide details of the employee's working week
Tick the days when they were rostered to work

Week 1 – the week of **this crash**

Mon	Tue	Wed	Thu	Fri	Sat	Sun
☐	☐	☐	☐	☐	☐	☐

Week 2 – the **following** week

Mon	Tue	Wed	Thu	Fri	Sat	Sun
☐	☐	☐	☐	☐	☐	☐

Average hours per day ☐

From ☐ To ☐

What is the employee's normal weekly wage? Gross ☐

Net

Have any amounts been paid to the employee for their absence from work?

No ☐

Yes – provide the following details

Nature of payment (e.g sick leave, annual leave etc) ☐

Date paid from ☐ Date paid to ☐

Gross amount paid ☐ Net amount paid ☐

Are you continuing to pay the employee? No ☐

Yes ☐

When will payments cease?

At the time of the crash **how much** and **what type of leave** was available to the employee?

On the day of the crash, was the employee on any type of leave from work, or were they due to commence leave within 4 weeks from the date of the crash?

No ☐ Yes ☐

If yes, please specify the type of leave (e.g sick leave, annual leave, maternity leave, unpaid leave etc) ☐

Is regular overtime available to the employee? No ☐

Yes ☐

Average hours worked each week over the three months prior to the crash

Claim Number:

Please provide details of the employee's weekly wages over the 4 week period immediately before the crash.

Week Ending	Gross Normal Wage	Hourly Rate of Pay	Overtime	Shift Allowance	Other Allowances (Type)	Allowance Amount	Tax	No. Hours Worked	No. Days Worked
Example Only	***$435.00***	***$11.18***	***$120.00***	***Nil***	***Weekend Site Height***	***$9.00 $16.70 $12.50***	***$190.00***	***44***	***5.5***

Alternatively provide copies of the employee's pay slips for the 4 weeks prior to the crash.

8. Miscellaneous

Are you related to your employee?

No ☐ Yes ☐

How are you related (e.g employee is brother, sister, de facto etc)?

Do you have a person to assist the employee to return to work?

No ☐ Yes ☐

Contact Name

Telephone Number

Has the employee lodged a Workers Compensation claim ***as a result of this crash***?

No ☐ Yes ☐

Provide details of the insurer

Claim Number

*Has the employee had any **previous** Workers Compensation claims?*

No ☐ Yes ☐

Provide details of the nature of the injury, date of injury and claim number

Claim Number:

I declare that the information provided in this form is, to the best of my knowledge, true and correct. It is an offence to provide false or misleading information in this document. Section 27B *Motor Vehicle (Third Party Insurance) Act 1943* – penalty $10,000.

Signature of employer's representative

Contact telephone number

IF YOU ARE UNABLE TO INSERT A
DIGITAL SIGNATURE TYPE NAME HERE

Date

Employer's business stamp

Name of employer's representative

Information Confidentiality

Please note that Section 42 of the *Insurance Commission of Western Australia Act 1986* prevents the Insurance Commission of Western Australia from divulging information, except in the performance of a function or duty under or in connection with any written law or as required by any other legal duty.

The Insurance Commission of Western Australia collects personal information through this form as authorised by law to assess motor injury insurance claims. If you are making such a claim, please note that to enable us to manage your claim, we will continue to collect other personal information from you and other relevant parties such as the WA Police Force, Department of Health, Department of Transport and Major Infrastructure, St John Ambulance, health service providers and solicitors. Personal information in this form is 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.

Authority to Release Information

I, _____of_____
authorise my employer to release to the Insurance Commission of Western Australia or its representative(s) any and all information in respect of my business(es) and employment. Furthermore, I authorise any insurer from whom I have claimed or held a policy with, for personal injury, to release to the Insurance Commission of Western Australia, all details in respect of such claim or policy.

Signed _____ Date _____

IF YOU ARE UNABLE TO INSERT A
DIGITAL SIGNATURE TYPE NAME HERE

Claim Number:

Download the form on your computer, and once complete, send to ctp@icwa.wa.gov.au

PRINT CLEAR