Insurance Commission of Western Australia

Government Insurance Division
Level 15, Tower 2
Mia Yellagonga, 5 Spring Street
Perth WA 6000
GPO BOX L920
Perth WA 6842
Tel:(08) 9264 3333
icwa.wa.gov.au

Personal Injury/Property Damage Report

Cover number:

Incident number:

(Office use only)

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.

- This form is to be completed by a person claiming against a Government of Western Australia Public Authority (agency) for an incident, accident, personal injury and/or property damage or loss.
- The completed form is to be submitted directly to the agency.
- The agency may refer claims to the Insurance Commission for assessment on behalf of the agency.
- The completion of this form and its receipt by the agency, and/or the Insurance Commission **is not an admission of liability, whether implied or expressed**.
- The Insurance Commission is responsible for assessing claims on behalf of the agency.

1. Agency details

Agency name:	
Address:	
Contact name:	
Phone:	Email:

2. Claimant details

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

3. Incident details

Date of incident:	Time: am/pm
Location of incident:	
Describe how the incident occurred:	
Weather conditions at time of incident:	
Who or what is considered to have caused the incident and why:	
Describe your injuries and the bodily location of the injury (e.g. cut to left arm, etc.):	
Was the incident reported to the Police or other authority? Yes ☐ No ☐	If yes, report number:
Did you require medical attention? Yes ☐ No ☐	If yes, is the treatment continuing: Yes ☐ No ☐
Name of medical practitioner attending:	
Address of medical practitioner attending:	

What treatment have you received:		
On what dates did you receive medical treatment?	From:	To:
Were you certified unfit for work? Yes ☐ No ☐ If yes provide dates:	From:	To:

4. Witness details (if applicable)

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

5. Property damage/loss (if applicable)

Was the property lost or damaged wholly owned by you? Yes ☐ No ☐ If no, please provide details of ownership:	
Name:	
Address:	
Phone: Email:	
Date of loss or damage:	Time: am/pm
Was the incident reported to the Police or other authority? Yes ☐ If yes, please provide the report number: No ☐	
If yes, advise to whom it was reported and date:	
Describe the location where the loss or damage occurred:	
Describe the circumstances that resulted in the loss or damage:	
Who or what is considered to have caused the loss or damage and why:	
Have any repairs been carried out at the property since the incident? Yes ☐ If yes, please attach repairers report, quotations or invoice. No ☐	
Is there any other insurance(s) covering this claim? Yes ☐ No ☐	If yes, please provide the policy number:
Insurance company:	
Nature of policy:	
Has a claim been made? Yes ☐ No ☐	If yes, please provide the claim number:

Schedule of property lost or damaged

Items lost or damaged	Quantity	Date of purchase	Total replacement cost price	Original purchase price*

*attach proof of purchase if available

6. Claimant declaration (must be signed by parent or guardian if claimant is under 18 years of age)

I declare that the details submitted are true and correct. Signature: Date:	
Name:	
Phone:	Email:
Relationship to claimant if not claimant:	