



Employer's Indemnity Journey Report

Claim no.

: : : : : : : : : : :

Policy no.

: : : : : : : : : : :

The form should be completed and returned to CGU Workers Compensation within 7 days of receipt by the insured. This form should be accompanied by employee report form and witness statement form.

In order for your Employer or CGU to assess or otherwise deal with your claim we need to collect certain personal information. The information will be kept confidential and will only be used and disclosed for purposes related to assessing or otherwise dealing with your claim. Further details on our Privacy Charter and how we deal with personal information, including access to your information, is available from any CGU Insurance office or visit our website at www.iag.com.au/privacy.

Please print in block letters and answer all Questions where applicable (provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

Employer details		
Name of business	Contact	
Employer's address	Postcode	
Telephone no. ()	Mobile no. ()	Facsimile no.

Injured person's details		
Surname/Family name	First name	
Address	Postcode	

Claim details		
Date of occurrence / /	Time	am/pm
Where did the injury occur?	Street	Suburb
State clearly and fully how the accident occurred.		

Journey details	
Where did the journey commence from?	
What was your destination?	
What was the purpose of your journey?	
Were you under instructions from your employer during the journey? No <input type="checkbox"/> Yes <input type="checkbox"/> What were they?	
Provide full details of route taken	
Is this the normal route for the journey? Yes <input type="checkbox"/> No <input type="checkbox"/> Why was this route taken?	
Prior to the accident, was your journey interrupted for any reason? No <input type="checkbox"/> Yes <input type="checkbox"/> What was the reason?	

If this is an accident involving a motor vehicle, please also complete the next page.

Injured person's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief.

I consent to my Employer and CGU Workers Compensation, in assessing or otherwise dealing with this claim, disclosing my personal information to or collecting my personal information from related entities, other insurers, insurance reference bureaux, investigators, or other parties providing services to the Insurer. To the best of my knowledge and belief, all the information given in this form is true and correct.

Name of injured person	Signature	Date / /
Name of witness	Signature	Date / /

Failure to complete this declaration may delay approval of this claim.

