QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Recurrence Claim Form

QBE WORKERS Compensation

To be completed where an injured person has lost further time following a return to work or where there has been a renewal of treatment of the original disability.

Injured Person's Details

Surname

Given Names

Address

Postcode

Current Employer

Claim Number

Employer at time of original disability

Nature of disability

Date of original disability/injury
/ /

Date of further period of incapacity
/ /

Date of return to work
/ /

Recurrence Details

Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred.

If a further incident occurred please provide details of this further incident.

Were there any witnesses to the onset of further symptoms? Yes ☐ No ☐

If yes, please provide names and addresses and attach statements

Recurrence Details *continued*

Was the onset of symptoms reported? Yes ☐ No ☐ If yes, when?

To Whom?

State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms.

What medical treatment have you been receiving prior to the latest onset of symptoms? State names of treating doctors and dates of treatment.

Please supply the following information for the period between the date of the original disability and current disability.

Employer	Dates Worked	Occupation
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	

Injured Person's Declaration

I solemnly and sincerely declare that each and every answer on this form 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 also hereby authorise any doctor to divulge to my Employer, or his or her insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regard to myself.

Dated this day of 20

Signature of Injured Person Date / /

Name

Signature of Witness Date / /

Name