Total Claims Solutions

Incolink

EMERGENCY TRANSPORT CLAIM FORM

OFFICE USE ONLY	Claim Number	Reference Number

The Emergency Transport Scheme covers Workers and their immediate families which includes the spouse/de-facto and dependant children only, for ambulance usage anywhere in Australia, as per the guidelines set by Incolink.

Dependant means; the Worker's spouse (or partner with whom the Worker has cohabited for not less than 3 consecutive months) and includes the unmarried financially dependant children of the Worker up to 16 years of age or up to 25 years of age if a FULL TIME STUDENT.

INSTRUCTIONS
1. This form is to be completed, once you have received the ambulance invoice.
2. Attach the ORIGINAL Ambulance invoice.

IMPORTANT
- A claim cannot be assessed until we receive the ORIGINAL claim form, completed in FULL.
- The issue of this form does not constitute an admission to liability on the part of Us.

Please forward the claim form to:

TOTAL CLAIMS SOLUTIONS PTY LTD
A.B.N. 42 389 515 023
Level 1, 151 Rathdowne Street, Carlton, Victoria 3053
PHONE: (03) 9663 2411 FAX: (03) 9663 4020

SECTION A WORKER DETAILS

Incolink Member Number		Union (Please tick one)	CFMEU ☐	CEPU ☐	AMWU ☐	OTHER ☐
Worker Surname		Given name(s)				
Address (No PO Box)		State		Postcode		
Telephone Private ( )	Business ( )	Mobile				
Date of Birth		Sex	☐ Male ☐ Female	Occupation		
Marital Status	☐ Single ☐ Married ☐ De-facto					

SECTION B AMBULANCE DETAILS (ATTACH ORIGINAL AMBULANCE INVOICE)

Name of the person claiming.			
Date of Birth (person using the ambulance)		Relationship to worker (i.e. son, de-facto)	

If defacto, attach copy of a bill determining you both reside at the above address. If a child is over the age of 16, provide a copy of their Student ID card.

Give the exact date and time the Ambulance was required.		Time	am/pm

State in full detail the reasons for the ambulance usage and the circumstances of the usage.

Was the ambulance required as a result of a motor vehicle accident?	☐ NO ☐ YES	Was the ambulance required as a result of a work accident?	☐ NO ☐ YES
Are you a Health Care Card holder?	☐ NO ☐ YES If yes, please provide health care card number? ____________________		

Payment Method

Pay direct to Ambulance Service.	☐ Please tick.	Please send cheque payable to me.	☐ Please tick.

SECTION C EMPLOYMENT DETAILS

Name of Company		Are you a	☐ Casual ☐ Part-time ☐ Full time ☐ Apprentice
Date commenced with company?	_____/_____/_____	Are you still employed?	☐ YES ☐ NO If NO when did you cease? _____/_____/_____

DECLARATION & AUTHORISATION

I hereby authorise any Australian Ambulance Service or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim.

I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I also declare that the information provided on this claim form is to the best of my knowledge and believe to be true in every respect. I understand that supplying false or misleading information will result in my right to compensation being forfeited. I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

Signature		Date	