

SECTION TWO - ILLNESS

Give the exact date your illness commenced?															
When did you cease work as a result of this illness?															
State in full detail the illness/es you are suffering from - "Medical condition" is not sufficient															
Is your illness related to your employment? <input type="checkbox"/> NO <input type="checkbox"/> YES															
If yes, have you lodged a claim with WorkCover? If so, please advise the name of the WorkCover insurer and your claim number															
Insurer											Claim Number				
How many PSL days are you claiming?															
PLEASE SUPPLY YOUR MEDICAL CERTIFICATE & MOST CURRENT PAYSIP															

PRIVACY

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com or contact the Compliance Manager on (02) 9375 4656 or email compliance.manager@qbe.com for further information.

PAYMENT DETAILS

If your claim is accepted, please advise what method you would like to receive payment.

Cheque Electronic Fund Transfer

To enable your benefits to be paid directly into your bank account you need to fill in your bank details below. This will give you direct access to the funds instead of waiting for a cheque to be cleared.

PLEASE NOTE: We depend on the accuracy of the details you are providing to us. Please write clearly and check with your bank if you are unsure of the bank details.

Name of Bank											Bank Phone Number								
BSB Number (6 digits)							Type of Bank Account i.e. Savings												
Bank Account Number							Name in which Account is held												
I, _____ (name in full)																			
Hereby authorise QBE Insurance (Australia) Limited and or Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.																			
Signature											Date								
Print Name																			

DECLARATION & AUTHORISATION BY PERSON CLAIMING

- I authorise any hospital, physician or other person who has attended me, or any employer, to give QBE Insurance (Australia) Limited or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records relevant to my claim including verification of earnings can be provided.
- I give permission for QBE Insurance (Australia) Limited or its representative to obtain a copy of any police report with respect to my claim.
- A photocopy of this authorisation will be considered as effective and valid as the original.
- I understand that Total Claims Solutions Pty. Ltd act as claims managers on behalf of QBE Insurance (Australia) Limited.
- I also authorise that QBE Insurance (Australia) Limited, or its representatives, to give to and obtain from other insurers and/or statutory authorities, or their representatives, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.
- I also agree for Incolink to supply details of my employer payments to assist with my claim.
- I also authorise QBE Insurance (Australia) Limited or its representative to refer my claim to Incolink's Member Service Department, if required.
- I declare that the preceding statements and information are, to the best of my knowledge and belief, true in every aspect.
- I understand the claim may be refused if information is not true or is withheld.

The signatory must be authorised to sign on behalf of all named persons.

Signature											Date								
Print Name																			

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM

SECTION B - THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER

Business/Trading Name					
Incolink Employer Number					
Address					
		State		Postcode	
Telephone Number	()	Fax Number	()		
E-mail					

Name of Employee																				
What is the Employee's Job Classification? (occupation).																				
I Hereby declare that the above employee has used all his/her sick leave entitlements under the award as detailed and needs to claim the balance of his/her sick days taken from the Incolink Portable Sick Leave Scheme.																				
The employee's hourly base rate of pay at the time of the injury/illness		\$																		
The employee works _____ hours per week (not including any overtime/RDO ie, 38)																				
What date did the employee commence working for you?		____/____/____																		
What date did the employee last work, as a result of his/her injury/illness?		____/____/____																		
Is the employee still employed with the company?		<input type="checkbox"/> NO <input type="checkbox"/> YES If no, please state date of termination: ____/____/____																		
Supply address of worksite where worker was stationed prior to injury/illness.																				
Has the employee returned to work? If so, please confirm date.		____/____/____																		
How many paid sick leave days has the company paid prior to this claim?		Number of Days _____																		
Also, please advise last sick day paid.		____/____/____																		
How many paid sick leave days including R.D.O's and Annual Leave have been paid against this claim. Please complete the following																				
Type	Total no. of days paid	Period paid																		
Sick Days		From								To										
R.D.O's		List days																		
Annual leave		List days																		
What proof was provided to you by the employee for the sick days taken?																				

I hereby declare that the information I have provided on this form is to the best of my knowledge and belief, true in every respect.			
Officer's Name (Print)		Position	
Telephone Number		RTW Coordinator	
Signature		Date	____/____/____

PLEASE ATTACH COPY OF CURRENT PAYSリップ

