



PERSONAL ACCIDENT CLAIM FORM

OFFICE USE ONLY	Claim Number	Reference Number
	<input type="text"/>	<input type="text"/>

This form is to be completed when a Worker has suffered an accident, outside working hours and wishes to claim Weekly Benefits, Capital Benefits and or Broken Bones benefits under the Redundancy Payment Central Fund Ltd, "Outside Working Hours – Injury/Journey", Insurance program.

The form has three parts which need to be fully completed.

Section A WORKER'S STATEMENT

The worker needs to complete ALL questions in this section of the form, being the first 3 pages. Incomplete answers and vague information will delay the assessment of your claim.

Section B ATTENDING PHYSICIANS STATEMENT

The workers treating doctor must complete the Attending Physicians Statement following completion by the Worker of the Workers statement (section A). Any charge for completion of this statement must be borne by the worker.

Section C EMPLOYER STATEMENT

The workers employer must complete Section C of this form.

IMPORTANT

- A claim cannot not be assessed until we receive the ORIGINAL claim form, completed in FULL, by the Worker, Attending Physician and Employer.
- 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
(Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited)
Level 1, 151 Rathdowne Street, Carlton, Victoria 3053
PHONE: (03) 9663 2411 FAX: (03) 9663 4020

SECTION A WORKER DETAILS

Incolink Member number	<input type="text"/>	Union (Please tick one)	CFMEU <input type="checkbox"/>	CEPU <input type="checkbox"/>	AMWU <input type="checkbox"/>	OTHER <input type="checkbox"/>	
Worker Surname	<input type="text"/>	Given name(s)	<input type="text"/>				
Address (No PO BOX)	<input type="text"/>			State	<input type="text"/>	Postcode	<input type="text"/>
Telephone	Private () <input type="text"/>	Business () <input type="text"/>	Mobile	<input type="text"/>			
Date of Birth	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	Kg
Occupation	<input type="text"/>			Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto						

DEPENDANTS

IF YOU ARE CLAIMING FOR DEPENDANT BENEFIT, PLEASE LIST AND PRODUCE DOCUMENTATION TO SUPPORT ONE OF YOUR DEPENDANTS.

Dependants means; the worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months) whose gross earnings are less than \$16,000 in the 12 months immediately prior to the date of injury, or 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.

Full Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
-----------	----------------------	---------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

EMPLOYMENT DETAILS

Name of Company	<input type="text"/>	Telephone	<input type="text"/>
Are you a (please tick)	<input type="checkbox"/> Casual <input type="checkbox"/> Part-time <input type="checkbox"/> Full time <input type="checkbox"/> Apprentice		
What date did you commence employment with this company?	<input type="text"/>		
Are you still employed?	<input type="checkbox"/> NO <input type="checkbox"/> YES		
If no when did you cease employment?	<input type="text"/>		

PLEASE ATTACH A COPY OF YOUR LAST PAY SLIP

TREATMENT DETAILS

Are you receiving treatment for your injury? If yes, please give details of the treatment you are presently receiving.											
Type of treatment											
Date commenced				Date of next treatment				Date treatment ceased			
Name and contact no.of provider						Name			Telephone		

MEDICAL & CLAIMS HISTORY

What other medical or surgical treatment have you received during the past 5 years?											
Date			Nature of treatment				Doctor's Name			Address	
Are you making or entitled to make any other insurance or compensation claim in respect of this disability?											
Sick Leave		<input type="checkbox"/> NO	<input type="checkbox"/> YES	Motor Compensation		<input type="checkbox"/> NO	<input type="checkbox"/> YES	WorkCover		<input type="checkbox"/> NO	<input type="checkbox"/> YES
Private Health Fund		<input type="checkbox"/> NO	<input type="checkbox"/> YES	Other Government Benefits		<input type="checkbox"/> NO	<input type="checkbox"/> YES	Superannuation Life Insurance		<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____			Name of fund/insurance company								
Case Manager				Claim Number				Telephone			

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 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 Total Claims Solutions Pty. Ltd. to release my personal information to Incolink's Member Service Department.
- 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											

SECTION B - ATTENDING PHYSICIAN'S STATEMENT

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

TO BE COMPLETED BY YOUR TREATING DOCTOR / SURGEON

Patient's Name	Age	Occupation

Patient's Address	
-------------------	--

Exact nature of patient's injury. Please list in full detail all injuries the patient is disabled from.

PLEASE ENCLOSE RESULTS OF ANY TESTS PERFORMED, WHICH HAVE DETERMINED THE ABOVE DIAGNOSIS.

The date of the patient's injury	____/____/____
When did the patient first consult you for this injury?	____/____/____
When did the patient last consult you for this injury?	____/____/____

Please advise the circumstances of the patient's accident and where the accident occurred.

If the patient's injury was not as a result of an accident what is the cause of the patient's injury?

Are there any conditions impacting the patient's disablement? Please give details.

Did the patient sustain an accident at work? Please give details.

Has the patient's work activities caused or significantly contributed, aggravated, accelerated, or exacerbated or deteriorated a pre-existing condition causing the patient's current disablement? Please give details.

Was the patient playing in competitive sport at the time of his/her accident? If "Yes" please provide details.

Are you aware if the patient has in the past or currently participates in any sporting activities, whether it be a team or individual sport? Please provide any details.

--

Give details of any circumstances such as the use of alcohol and or drugs, which may have caused or significantly contributed to the patient's accident. Please also include BAC readings, if taken.

--

How long have you known this person in a professional capacity?	Years	Month
---	-------	-------

SECTION B - ATTENDING PHYSICIAN'S STATEMENT - CONTINUED

Has patient ever had the same or a similar condition? If "Yes" state when and describe whether this has an impact on current disablement

Has the patient been hospitalised? NO YES If yes, Name of Hospital

Date of Admission ____/____/____ to ____/____/____ What date was the treatment prescribed? ____/____/____

Please give full details of treatment prescribed and results of that treatment including any surgery or medication prescribed.

Has treatment been terminated? If so, please give date ceased.

Frequency of Visits Weekly Monthly Other _____

Is the patient following your prescribed treatment? NO YES If No, please give details.

When will the patient be fit to return to his/her normal occupation or alternative duties? Please state which.

Are there any complications that may delay the recovery? If Yes, provide details.

What is your prognosis?

Have you told the patient to restrict employment activities? If so, please advise the date the restrictions commenced and ended.

Commenced _____ Ended _____

Explain the specific restrictions and limitations.

Do you expect a fundamental or marked change in the patient's injury? If yes, when will the patient recover sufficiently to return to work? 1 month 1-3 months 4-6 months Other _____

Can present job be modified to allow the patient to work with their disability? If yes, please advise the date the trial will commence and indicate whether full-time or part-time. If part-time, how many hours per day/week.

Would vocational counselling and/or retraining be recommended? If yes, please specify.

With regard to the patient's occupation, how long was or will patient be continuously totally disabled? (Unable to perform any part of his/her occupation)

TOTALLY DISABLED FROM: _____ TO: _____ (BOTH DATES INCLUSIVE)

How long was or will patient be partially disabled? (Unable to perform some part of his/her occupation)

PARTIALLY DISABLED FROM: _____ TO: _____ (BOTH DATES INCLUSIVE)

Name (Please Print)

Date

Address (Please Print)

Phone Number ()

Fax Number ()

E-mail

E-mail

Medical Qualifications

Signed

SECTION C - 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).			
Please state the Employees current Gross weekly earnings excluding overtime & allowances at the date of injury. (The base rate of pay).	\$		
Reason employee stopped working?	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Other (please specify) _____
Is the employee entitled to Workers' Compensation benefits?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If yes, please confirm the details of this claim including a copy of the WorkCover Claim form
Insurer		Claim Number	

ATTACH A COPY OF THE JOB DESCRIPTION CARRIED OUT BY THE EMPLOYEE.

If employee was partially disabled (fit for light duties), would any sedentary (light/manual work or administration) work be available? If so, please give details.

--

RTW Coordinator's Name		Telephone	
Was the worker employed at the time of suffering the accident?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If yes, provide address and worksite where worker was stationed prior to injury?
What date did the employee commence working for you?	____/____/____		
The date the employee last worked for you, prior to the accident?	____/____/____		
Has the employee returned to work?	<input type="checkbox"/> NO <input type="checkbox"/> YES		
	If yes, what date? ____/____/____		
Has the employee received any sick leave payments in respect of the injury being claimed?	<input type="checkbox"/> NO <input type="checkbox"/> YES Number of days ____		
The last date the employee was paid sick leave .	____/____/____		
How many sick leave days does the employee have owing?	Number of days entitled _____		

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 ()	E-mail		
Signature		Date	____/____/____

PLEASE ATTACH COPIES OF ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY.