



ILLNESS CLAIM FORM

OFFICE USE ONLY

Claim Number

Reference Number

This form is to be completed when a Worker suffers an illness, outside working hours and wishes to claim weekly benefits under the Redundancy Payment Central Fund, Outside Working Hours - Illness, 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 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		Union (Please tick one)	CFMEU <input type="checkbox"/>	CEPU <input type="checkbox"/>	AMWU <input type="checkbox"/>	OTHER <input type="checkbox"/>
Worker Surname			Given name(s)			
Address (No PO BOX)					State	Postcode
Telephone	Private ()	Business ()		Mobile		
Date of Birth		Height	cm	Weight	Kg	
Occupation				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		Date of Birth							
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EMPLOYMENT DETAILS

Name of Company		Telephone	
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?	____/____/____		
Are you still employed?			
If no, when did you cease employment?	____/____/____		

PLEASE ATTACH A COPY OF YOUR LAST PAY SLIP

ILLNESS DETAILS

Give the exact date your illness commenced.																					
When did you cease work as a result of this illness?																					am/pm
Have you returned to work? If so, please provide date.																					
If you have not returned to work, please advise the date you expect to return to work.																					
State in full detail, the illness/es you are suffering from.																					
Did your illness result due to your employment?										<input type="checkbox"/> NO <input type="checkbox"/> YES		If your illness is work related, have you lodged a claim with WorkCover? If so, please advise the name of your WorkCover insurer and claim number.									
Insurer										Claim Number											
Have you had a similar condition before?										<input type="checkbox"/> NO <input type="checkbox"/> YES		If yes, give details of the physician/hospital or specialist attended.									
Doctor's Name					Address					Telephone					Date attended						

YOUR PHYSICIAN'S DETAILS

Give the name and address of first physician/hospital or specialist attending to you for this illness.										
Date Treated		____/____/____								
Name										
Address							State		Postcode	
Details of all other attending physicians and dates attended										
Doctor's name		Address			Telephone			Date attended		
Who is your usual family doctor?										
Doctor's name			Address				Telephone			
How long have you been receiving treatment or advice from this doctor?					Years			Months		

TREATMENT DETAILS

Are you receiving treatment for your illness? If yes, please give details of the treatment you are presently receiving. Please complete the following table.										
Type of treatment										
Date commenced		Date of next treatment			Date treatment ceased					
Name and contact number 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 now, or have you ever been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? No Yes (give details)

Have you ever lodged a personal accident or illness claim before? No Yes (give details)

Are you making or entitled to make any other insurance or compensation claim in respect of this disability?

Sick Leave NO YES Motor Compensation NO YES WorkCover NO YES

Private Health Fund NO YES Other Government Benefits NO YES Superannuation Life Insurance NO 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 hereby authorise any hospital, physician, police authority, or any employer or any other person who has attended me to furnish Total Claims Solutions Pty Ltd and or QBE Insurance (Australia) Limited or its representatives with any and all information with respect to my injury/illness, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers including verification of earnings.
- I agree that a Photostat copy of this authentication shall be considered as effective and valid as the original.
- I also authorise Total Claims Solutions Pty Ltd and or QBE Insurance (Australia) Limited, give to and obtain from any statutory workers compensation scheme or any statutory transport accident scheme or any other insurers, any reference bureaus and credit reporting agencies, any information relating to my insurance history as well as insurance claims information during the course of this contract. I also understand that Total Claims Solutions Pty Ltd, have been appointed as Claims managers on behalf of QBE Insurance (Australia) Limited.
- 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 information I have provided on this form is to the best of my knowledge and belief, true in every aspect.
- I understand that supplying false or misleading information will result in my right to compensation being forfeited.

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	
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Please state in full detail the primary illness causing the patient's disablement.

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PLEASE ENCLOSE COPIES OF ALL TESTS RESULTS, IF ANY, WHICH HAVE DETERMINED THE ABOVE LISTED DIAGNOSIS.

Please list all other illness/es, if any, affecting the patient's disablement?

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When did the patient first consult you for this illness?	____/____/____
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When did the patient last consult you for this illness?	____/____/____
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What is the cause of the patient's illness?	
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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.

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Give details of any circumstances such as the use of alcohol and or drugs, which has caused and or significantly contributed to the patient's illness.

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How long have you known this person in a professional capacity?	Years	Months
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Has the patient ever had the same or similar condition? If "Yes" state when and describe whether this has an impact on current disablement.

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Please supply the first initial date followed by the periods, you have given advice to the patient for this or any related illness. Please include the nature of consultation/s.

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Has the patient been hospitalised?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, Name of Hospital _____
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Date of Admission	____/____/____ to ____/____/____
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SECTION B ATTENDING PHYSICIAN'S STATEMENT - CONTINUED

What date was the treatment prescribed?																																							
Please advise what prescribed medication and treatment was given to the patient for this or any related illness including the duration of such treatment/medication.																																							
Has treatment been terminated? If so, please give date ceased.																																							
Frequency of Visits		<input type="checkbox"/> Weekly		<input type="checkbox"/> Monthly		<input type="checkbox"/> Other		_____																															
Is the patient following your prescribed treatment?										<input type="checkbox"/> NO		<input type="checkbox"/> 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 regarding recovery?																																							
What is your prognosis?																																							
Have you told the patient to restrict employment activities? If so, please advise the date the restrictions began and the date the restrictions ended.																																							
Date Commenced																				Date Ended																			
Explain the specific restrictions and limitations.																																							
Do you expect a fundamental or marked change in the patient's illness?										<input type="checkbox"/> 1 month		<input type="checkbox"/> 1-3 months				<input type="checkbox"/> 4-6 months				If yes, when will the patient recover sufficiently to return to work?				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 and per 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)																																							
Telephone										()		Fax Number				()																							
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	()	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 illness. (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 so, please confirm the details of this claim also including a copy of his/her 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.

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RTW Coordinator's Name				Telephone	
Was the worker employed at the time of suffering the illness?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If Yes, supply address and worksite where worker was stationed prior to illness?		

What date did the employee commence working for you?									
The date the employee last worked for you, prior to the illness?									
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 to the illness 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 ILLNESS.