

TAC TOP-UP CLAIM FORM

OFFICE USE ONLY	Claim Number	Reference Number

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

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

Section A WORKERS 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

The workers employer must complete Section C of this form.

IMPORTANT

- A claim, cannot not be assessed until we receive the 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 all correspondence 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 MEMBER DETAILS

Incolink Membership number		Union (Please tick one)	CFMEU <input type="checkbox"/>	CEPU <input type="checkbox"/>	AMWU <input type="checkbox"/>	OTHER <input type="checkbox"/>
Member	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					

CLAIMING FOR DEPENDANTS

Please list and produce documentation to support ONE of your dependants to be eligible for benefits available for Member with 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 per year in the 12 months immediately prior to the date of injury, and 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

EMPLOYMENT DETAILS (ATTACH A COPY OF PAYS LIP)

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

PLEASE ATTACH A COPY OF YOUR LAST PAY SLIP

ACCIDENT DETAILS

Give the exact date and time the accident occurred.										am/pm	
When did you cease work as a result of this injury?											
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 exactly how the accident occurred, together with the circumstances surrounding your accident, ie what were you doing prior to the accident.											
Were you travelling to or from work at the time of your accident?										<input type="checkbox"/> NO <input type="checkbox"/> YES	
Address where accident occurred?											
Where had you been travelling from? (provide address and whether it was a work site or home. Shops etc)											
Where were you travelling to? (address, and whether it was work, home shops etc)											
Did any police attend the accident? If yes, please advise the name and station the police officers were from.											
Name & Addresses of any witnesses to the accident.		1. Name			Address						
		2. Name			Address						
Have you lodged a claim through TAC? If so, please provide your claim number, claims officer handling your claim and contact details.											
Name of Claims Officer				TAC Claim Number				Phone Number			
Had you consumed any alcohol or drugs within the 8 hours prior to the accident?										<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, amount _____ Where _____											
Have you had a similar condition before? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please supply the name and address of the physician you attended)											
Address				State				Postcode			

PHYSICIAN'S DETAILS

Give the name and address of first physician/hospital or specialist attending to you for this injury.											
Name											
Address						State		Postcode			
Date Treated											
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 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				

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 (If yes, please give details)

Have you ever lodged a personal accident or illness claim before? NO YES (If yes, please give details)

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
Workers compensation	<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 _____					

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 methods 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, _____ (employee's 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		Print Name		Date	
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DECLARATION & AUTHORISATION BY PERSON CLAIMING

1. 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 it's 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.
2. I agree that a Photostat copy of this authentication shall be considered as effective and valid as the original.
3. I also authorise that 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, who have been appointed as Claims managers on behalf of QBE Insurance (Australia) Limited.
4. I also agree for Incolink to supply details of my employer payments to assist with my claim.
5. I declare that the information I have provided on this form is to the best of my knowledge and belief, true in every aspect.
6. I understand that supplying false or misleading information will result in my right to compensation being forfeited.

Signature		Date				
Print Name						

SECTION B - TO BE COMPLETED BY YOUR TREATING DOCTOR / SURGEON

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

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Age	Occupation

Patient's Address

Exact nature of patient's injury. Please list in full details 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?

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. NO YES

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?

Has patient ever had the same or a similar condition? NO YES

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 _____

Dates of Admission _____/_____/_____ to _____/_____/_____ What date was the treatment prescribed? _____/_____/_____

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

Frequency of Visits Weekly Monthly Other _____

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	
E-mail					

What is the Employee's MBAV/CFMEU Job Classification? (occupation).					
Please state the Employees current Gross weekly earnings excluding overtime & allowances at the date of injury.					\$
Is the employee entitled to Workers' Compensation benefits?					
If so, please confirm the details of this claim <u>also including a copy of his/her WorkCover Claim form</u>					
Insurer				Claim Number	
Was the employee travelling to or from work at the time of the accident?	<input type="checkbox"/> NO <input type="checkbox"/> YES				
If yes, advise what site he/she was working on?					
Please advise whether the accident occurred prior to the employee arriving and commencing that days work or whether the accident occurred after the employee finished work that day.					
If the employee's accident occurred prior to he/she commencing that days work, please advise the time he/she was scheduled to commence work that day.					_____ am/pm
If the employee's accident occurred after he/she finished work that day, please advise the time he/she finished work.					_____ am/pm
Was the injury reported? If so, please supply incident details.					

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 to him/her? If so, please give details.					

What date did the employee commence working for you?					
Was the worker employed at the time of suffering the accident?	<input type="checkbox"/> NO <input type="checkbox"/> YES				
The date the employee last worked for you, prior to the accident?	____/____/____				
Has the employee returned to work for you?	<input type="checkbox"/> NO <input type="checkbox"/> YES				
	If yes, what date? ____/____/____				

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 COPIES OF ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED IN THE PAST SIX MONTHS