



# WORK COVER TOP-UP CLAIM FORM

OFFICE USE ONLY	Claim Number	Reference Number

This form is to be completed when a Worker has suffered a workplace accident, and has received in excess of 52 weeks of WorkCover benefits and wishes to claim top-up benefits from the 53rd week, under the Redundancy Payment Central Fund Ltd, "Outside Working Hours - WorkCover Top-Up".

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
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								
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## EMPLOYMENT DETAILS

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?										
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.										<input type="checkbox"/> No <input type="checkbox"/> Yes	
If you have not returned to work, please advise the date you expect to return to work.											
Describe your injury											
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.											
Did your accident occur on site? Please give details as to the job you were performing that day.											
Address where accident occurred?											
Name & Addresses of any witnesses to the accident.		1. Name			Address						
		2. Name			Address						
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 _____											
Supply details of your WorkCover claim.		Workcover Insurer			Claim Number						
Claims officer's Name					Telephone						
Have you had a similar condition before? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, give details including the name and address of the physician you attended)											
Doctor's name		Address									

## 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					
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 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.

## EMPLOYMENT HISTORY

Name of previous employers over last 5 years.		Period from (date)	To (date)
Name	Phone		
Name	Phone		

## 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](http://www.qbe.com) or contact the Compliance Manager on (02) 9375 4656 or email [compliance.manager@qbe.com](mailto: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	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 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.
- I also agree for Incolink to supply details of my employer payments to assist with my claim.
- 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 - 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 sustained.

**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.

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.

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 the patient ever had the same or 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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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



**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			
Name of Employee			
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?			<input type="checkbox"/> NO <input type="checkbox"/> YES
If so, please confirm the details of this claim <b>also including a copy of his/her WorkCover Claim form</b>			
Insurer		Claim Number	
<b>ATTACH A COPY OF THE JOB DESCRIPTION CARRIED OUT BY THE EMPLOYEE.</b>			
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.			
Was the worker employed at the time of suffering the accident?			<input type="checkbox"/> NO <input type="checkbox"/> YES
Supply 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 for which he/she is claiming?			<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		RTW Coordinator	
Signature		Date	____/____/____

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