Total Claims Solutions

CIP Income Protection

PORTABLE SICK LEAVE CLAIM FORM

OFFICE USE ONLY | Claim number | Reference

COMPLETE THIS FORM IF

You are a permanent worker who has suffered an accident or illness, **outside working hours** and have exhausted all available sick leave entitlements with your current contributing employer.

FORWARD THIS CLAIM FORM TO

Total Claims Solutions
Level 1, 62 Astor Terrace
Spring Hill QLD 4000

FOR CLAIM ENQUIRIES CALL

Total Claims Solutions
(07) 3230 9300

INSTRUCTIONS

Section A

The **WORKER** must complete ALL questions in Section A (pages 1–3) of the form and Part 1 if suffering an injury
OR
Part 2 if suffering an illness.

Incomplete answers and vague information will delay the assessment of the claim.

Section B

The worker's **EMPLOYER** must complete Section B (page 4) of this form.

IMPORTANT

The **ORIGINAL** fully completed claim form must be sent with **ALL DOCUMENTS** outlined in the checklist.

CHECKLIST

- ☐ Payslip
- ☐ Medical certificate(s)
- ☐ Medical report(s) – *if any*
- ☐ Job description

Casual and Sub-Contractors are **NOT** eligible to claim Portable Sick Leave entitlements.

The issue of this form **DOES NOT** constitute admission of liability on our behalf.

Section A — Worker

WORKER DETAILS

1. CIPL member number
2. Are you a union member ☐ No ☐ Yes ▶ Name of union
3. BUSSQ number
4. Given name(s) — Surname
5. Date of birth DD / MM / YYYY
6. Address (no PO Box)
7. Home phone
8. Mobile
9. Email
10. Height cm
11. Weight kg
12. Marital status ☐ Married ☐ Defacto ☐ Single
13. Sex ☐ Male ☐ Female
14. Occupation
15. Do you require an interpreter ☐ No ☐ Yes ▶ Language

WORKER'S EMPLOYMENT DETAILS

16. Name of company
17. Phone
18. Date commenced DD / MM / YYYY
19. Employment status ☐ Full-time ☐ Part-time ☐ Casual ☐ Working Director ☐ Sub-Contractor
20. Are you still employed ☐ Yes ☐ No ▶ Date of termination DD / MM / YYYY

PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP

PART 1 – INJURY ONLY

21. Date of accident

DD / MM / YYYY

22. Exact time of accident

HH : MM am / pm

23. Date ceased work as a result of injury

DD / MM / YYYY

24. Describe your injury

25. Detail exactly how the accident occurred including what you were doing prior to the accident

26. Where did the accident occur

☐ Home ☐ Work ☐ Travelling to/from work ☐ Other

27. Did your accident occur at work

☐ No ☐ Yes ▶ Have you submitted a claim to Workcover ☐ No ☐ Yes ▶ Insurer

Claim number

Case manager

Phone

28. How many Portable Sick Leave days are you claiming

DD

PLEASE ATTACH MEDICAL CERTIFICATE(S) & ANY MEDICAL REPORT(S)

OR

PART 2 – ILLNESS ONLY

29. Date illness commenced

DD / MM / YYYY

30. Date ceased work as a result of illness

DD / MM / YYYY

31. Detail the medical condition(s) you are suffering from

32. Is your illness related to your employment

☐ No ☐ Yes ▶ Have you submitted a claim to Workcover ☐ No ☐ Yes ▶ Insurer

Claim number

Case manager

Phone

33. How many Portable Sick Leave days are you claiming

DD

PLEASE ATTACH MEDICAL CERTIFICATE(S) & ANY MEDICAL REPORT(S)

PRIVACY

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at www.qbe.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers. We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia. By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so. If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

PAYMENT DETAILS

34. If this claim is accepted, how would you like to receive payment(s)

☐ Cheque ☐ Electronic Funds Transfer ▶

Bank name	
Account name	Account type
BSB	Account number

We depend on the accuracy of the details you provide. Please write clearly and contact your bank if you are unsure of these details.

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 DD / MM / YYYY

DECLARATION AND 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 agree to provide a certified copy of photographic identification in the event that it is required to assist with management of the claim.

I understand that Total Claims Solutions Pty Ltd act as claims managers on behalf of QBE Insurance (Australia) Limited.

I authorise QBE Insurance (Australia) Limited, or its representatives, to give to and obtain from other insurers and/or statutory authorities, Workers' Compensation Regulatory Services and or Office of Industrial Relations and 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 agree for the administrators of my BUSSQ, BERT and CIPL to supply details of ALL employer payments and any other payments or entitlements I may receive.

I authorise QBE Insurance (Australia) Limited or its representative to give my employer information to the CIPL Board of Trustees, if requested.

I authorise QBE Insurance (Australia) Limited or its representative to refer my claim to Mates in Construction, if required.

I understand the claim may be refused if information is not true or is withheld.

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

Signature

Print name

Date DD / MM / YYYY

Acting as Claims Managers on behalf of
QBE Insurance (Australia) Limited ABN 78 003 191 035

Section B Employer

EMPLOYER DETAILS

1. Business/trading name

2. CIPL employer number

3. Address

4. Phone

5. Fax

6. Email

EMPLOYEE DETAILS

7. Name

8. Job classification/occupation

9. Employment status

☐ Full-time ☐ Part-time ☐ Casual ☐ Working Director ☐ Sub-Contractor

10. At the time of the injury/illness, what were the gross weekly earnings (base rate of pay) excluding overtime and allowances

Base hourly rate $ Standard hours worked per week hours

11. When did the employee work for you

Commencement date DD / MM / YYYY Last day worked prior to the injury/illness DD / MM / YYYY

12. Is the patient still employed with the company and accruing sick leave

☐ Yes ☐ No ▶ Termination / redundancy date DD / MM / YYYY

13. Has the employee received any payments in respect of this injury/illness for the following

☐ Sick leave ▶ Number of days Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ Annual leave ▶ Number of days Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ RDOs ▶ Number of days Provide dates

14. How many days does the employee have owing

Sick leave RDOs

15. Has the employee returned to work

☐ No ☐ Yes ▶ Date returned DD / MM / YYYY

16. What proof was provided by the employee for the sick days taken

PLEASE ATTACH MEDICAL CERTIFICATE(S), ANY MEDICAL REPORT(S) & JOB DESCRIPTION

DECLARATION BY EMPLOYER

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.

I declare this employee has used all their sick leave entitlements under the Award and needs to claim the balance of their sick days taken from the CIPL Portable Sick Leave Program.

Name

Position

Phone

Signature

Date DD / MM / YYYY

Total Claims Solutions Pty Ltd ABN 42 389 515 023
Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited
Level 1, 62 Astor Terrace, Spring Hill, Queensland 4000
T: (07) 3230 9300
F: (07) 3230 9399

www.totalclaims.com.au