

# WORKCOVER TOP-UP CLAIM FORM

**OFFICE USE ONLY**

Claim number

Reference

## COMPLETE THIS FORM IF

You have suffered a workplace accident and have received 26 weeks of Workcover benefits and wish to claim top-up benefits.

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

### Section B

The worker's **ATTENDING PHYSICIAN** must complete Section B (pages 4–5) only if Section A is complete.  
The worker will be responsible for any fee charged to complete this statement.

### Section C

The worker's **EMPLOYER** must complete Section C (page 6) of this form.

## IMPORTANT

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

## CHECKLIST

- Payslip(s) or Remittance(s) from 27th week
- Workcover claim form – *copy*
- Workcover acceptance letter
- 26 week reduction letter – *if issued*
- Medical report(s) – *if any*
- Job Description

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

## Section A

## Worker

### WORKER DETAILS

1. CIPL member number <input type="text"/>	2. Are you a union member <input type="checkbox"/> No <input type="checkbox"/> Yes <span style="border: 1px dashed black; padding: 2px;">Name of union</span>	3. BUSSQ number <input type="text"/>
4. Given name(s) <input type="text"/>	Surname <input type="text"/>	5. Date of birth <input type="text" value="DD / MM / YYYY"/>
6. Address (no PO Box) <input type="text"/>		
7. Home phone <input type="text"/>	8. Mobile <input type="text"/>	9. Email <input type="text"/>
10. Height <input type="text" value="cm"/>	11. Weight <input type="text" value="kg"/>	12. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Single
14. Occupation <input type="text"/>		13. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
15. Do you require an interpreter <input type="checkbox"/> No <input type="checkbox"/> Yes <span style="border: 1px dashed black; padding: 2px;">Language</span>		

### WORKER'S EMPLOYMENT DETAILS

16. Name of company <input type="text"/>	17. Phone <input type="text"/>
18. Date commenced <input type="text" value="DD / MM / YYYY"/>	19. Employment status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual <input type="checkbox"/> Working Director <input type="checkbox"/> Sub-Contractor
20. Are you still employed <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="border: 1px dashed black; padding: 2px;">Have you been made redundant <input type="checkbox"/> No <input type="checkbox"/> Yes <span style="border: 1px dashed black; padding: 2px;">Date of termination DD / MM / YYYY</span></span>	

**FROM THE 27TH WEEK OF WORKCOVER BENEFITS PLEASE ATTACH COPIES OF YOUR LAST PAYSリップ(S) OR YOUR PAYMENT/REIMBURSEMENT STATEMENT(S) IF WORKCOVER IS PAYING YOU DIRECT**

### ACCIDENT DETAILS

21. Date of accident <input type="text" value="DD / MM / YYYY"/>	22. Date ceased work as a result of accident <input type="text" value="DD / MM / YYYY"/>
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23. Have you returned to work

Yes  No  No  No

24. Describe your injury

Four empty text boxes for describing the injury.

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

Four empty text boxes for detailing the accident.

WORKCOVER DETAILS

PLEASE ATTACH A COPY OF THE WORKCOVER CLAIM FORM & WORKCOVER ACCEPTANCE LETTER

26. Workcover insurer

Name and Claim number input fields.

27. Workcover case manager

Name, Phone, Fax, and Email input fields.

PLEASE ATTACH A COPY OF THE 26 WEEK REDUCTION LETTER - IF ISSUED

PHYSICIAN DETAILS

28. Details of the first physician, hospital or specialist attending to your injury

Doctor, Phone, Date attended, and Address input fields.

29. Details of other attending physicians

Doctor 1, Phone, Date attended, and Address input fields.

Doctor 2, Phone, Date attended, and Address input fields.

30. Who is your usual family doctor

Doctor, Phone, How long have you been a patient at this practice, and Address input fields.

TREATMENT DETAILS

31. Are you receiving treatment for your injury

Form for listing treatment providers with checkboxes for No/Yes and fields for Provider, Type, and Phone.

## MEDICAL AND CLAIMS HISTORY

### 32. Medical or surgical treatment received related to this injury

Doctor	<input type="text" value="1."/>	Phone	<input type="text"/>
Address <input type="text"/>			
Treatment type	<input type="text"/>	Date	<input type="text" value="DD / MM / YYYY"/>
Doctor	<input type="text" value="2."/>	Phone	<input type="text"/>
Address <input type="text"/>			
Treatment type	<input type="text"/>	Date	<input type="text" value="DD / MM / YYYY"/>

### 33. Were you entitled to or did you make any other insurance or compensation claim for this accident

Motor Compensation  Private Health Fund  Superannuation Life Insurance  Other

▶ If you ticked any boxes please provide further details

Fund/Company	Claim number
Case Manager	Phone

## 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](http://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
<i>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.</i>	
Signature	Date <input type="text" value="DD / MM / YYYY"/>

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

## 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	<input type="text"/>
Print name	<input type="text"/>
Date	<input type="text" value="DD / MM / YYYY"/>

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



PATIENT DETAILS

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

1. Name 2. Age 3. Occupation

4. Address

ACCIDENT DETAILS

5. What is the diagnosis causing the patients incapacity

PLEASE ENCLOSE COPIES OF TEST RESULTS (IF ANY) WHICH HAVE DETERMINED THE ABOVE LISTED DIAGNOSIS

6. Date of injury 7. Date the patient first consulted you for this injury 8. Date the patient last consulted you for this injury

9. Advise the circumstances of the patient's accident and where it occurred

10. Are there any other conditions impacting on the patient's incapacity

11. Did the use of alcohol and/or drugs cause or significantly contribute to the patient's accident

12. How long have you known the patient in a professional capacity

TREATMENT DETAILS

13. Has the patient been hospitalised

14. Provide full details of treatment prescribed and the results including any surgery or medication

15. Have you provided any medical information to any other insurer regarding this injury

PLEASE PROVIDE MEDICAL REPORT(S) - IF ANY

16. Is the patient following your prescribed treatment

17. Frequency of visits 18. Has treatment been terminated

**CAPACITY FOR WORK**

19. Are there any complications that may delay the recovery

No  Yes  Provide details

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20. What is your prognosis for recovery

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21. What is the expected timeframe for recovery and return to full time work

> 1 month  1-3 Months  4-6 months  Other

22. Have you told the patient to restrict employment activities

No  Yes  Restrictions commenced **DD / MM / YYYY** Restrictions ceased **DD / MM / YYYY**

Explain the specific restrictions and limitations including hours per day/week

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23. Would vocational counselling and/or retraining be recommended

No  Yes  Provide details

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24. Is the use of drugs and/or alcohol affecting the patient's ability to recover and return to work

No  Yes  Provide details

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25. Is the patient still employed

Yes  No  Termination / redundancy date **DD / MM / YYYY**

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**DECLARATION BY PHYSICIAN / TREATING DOCTOR**

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.

Name	<input type="text"/>	Medical qualifications	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
Address	<input type="text"/>		<b>STAMP</b>          
	<input type="text"/>		
Phone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		

## 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

## ATTACH EMPLOYEE'S JOB DESCRIPTION

9. Employment status

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

10. Has the employee returned to work

 No  Yes 

11. Has the employee been made redundant

 No  Yes

12. If the employee is fit for suitable or alternative duties, would you be able to offer such duties

 No  Yes 

## 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.

Name

Position

Phone

Email

Signature

Date

**Total Claims Solutions Pty Ltd** ABN 42 389 515 023Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited  
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