

PERSONAL ACCIDENT CLAIM FORM

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

You have suffered an accident, **outside working hours** and wish to claim weekly 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 4–6) 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 (pages 7–8) of this form.

IMPORTANT

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

CHECKLIST

- Payslip
- Medical report(s) – *if any*
- Job description
- Workcover claim form – *if any*
- Medical certificate(s)

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 Have you been made redundant No Yes Date of termination DD / MM / YYYY

PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP

ACCIDENT DETAILS

21. Date of accident DD / MM / YYYY

22. Exact time of accident HH : MM am/pm

23. Date ceased work as a result of accident DD / MM / YYYY

24. Have you returned to work
 Yes Date returned to work DD / MM / YYYY No Expected return date DD / MM / YYYY

25. Describe your injury, how it happened and what you were doing prior to the accident

Three empty text boxes for describing the injury.

26. Where did the accident occur

Home Work Other [text box]

27. Address where accident occurred

[text box]

28. Name of witness(es)

Phone

1. [text box]

[text box]

2. [text box]

[text box]

29. Do you believe your employment caused or significantly contributed to your injury

No Yes Why do you believe your injury is work related

[text box]

30. Have you submitted a claim to Workcover

No Yes Insurer Claim number Case Manager Phone

31. Had you consumed any alcohol or drugs in the 8 hours prior to the accident

No Yes Location 1 Amount Location 2 Amount

32. Did the accident occur while training for or playing sport

No Yes Club name Phone

33. Have you had a similar condition before

No Yes Doctor Phone Address Date attended DD / MM / YYYY

PHYSICIAN DETAILS

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

Doctor [text box] Phone [text box] Date attended DD / MM / YYYY Address [text box]

35. Details of other attending physicians

Doctor 1. [text box] Phone [text box] Date attended DD / MM / YYYY Address [text box]

Doctor 2. [text box] Phone [text box] Date attended DD / MM / YYYY Address [text box]

36. Who is your usual family doctor

Doctor [text box] Phone [text box] How long have you been a patient at this practice YY / MM Address [text box]

TREATMENT DETAILS

37. Are you receiving treatment for your injury

No Yes Provider Phone Type Provider Phone Type Provider Phone Type

MEDICAL AND CLAIMS HISTORY

38. Medical or surgical treatment received during the last 5 years

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"/>

39. Are you entitled to or making any other insurance or compensation claim for this accident

Sick Leave Workcover 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, 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

40. 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 patient's 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. What caused the patient's accident

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

12. Did the patient sustain the injury at work

13. Has the patient's work activities caused or significantly contributed to, aggravated, accelerated, exacerbated or deteriorated a pre-existing condition causing the patient's current incapacity

14. Was the patient training for or playing sport at the time of their accident

15. Does the patient normally participate in team or individual sporting activities

16. Did the use of alcohol and/or drugs directly or indirectly contribute to the patient's accident

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

YY / MM

18. Has the patient ever had the same or a similar condition

No Yes

▶ State when and describe whether this has an impact on current incapacity

Dashed box for providing details of previous conditions.

TREATMENT DETAILS

19. Has the patient been hospitalised

No Yes

▶ From DD / MM / YYYY To DD / MM / YYYY Date treatment prescribed DD / MM / YYYY
Name of hospital Phone

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

Two empty text boxes for treatment details.

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

No Yes

▶ Insurer

Dashed box for insurer name.

PLEASE PROVIDE MEDICAL REPORT(S) - IF ANY

22. Is the patient following your prescribed treatment

Yes No

▶ Provide details

Dashed box for treatment details.

23. Frequency of visits

Weekly Fortnightly Monthly Other

Empty box for frequency of visits.

24. Has treatment been terminated

No Yes

▶ Date ceased DD / MM / YYYY

Empty box for date treatment ceased.

25. Is the patient still employed

Yes No

▶ Termination / redundancy date DD / MM / YYYY

Empty box for termination/redundancy date.

CAPACITY FOR WORK

26. Are there any complications that may delay the recovery

No Yes

▶ Provide details

Dashed box for complications.

27. What is your prognosis for recovery

Empty text box for prognosis.

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

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

Empty box for expected timeframe.

29. 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

Dashed box for employment restrictions.

30. Would vocational counselling and/or retraining be recommended

No Yes

▶ Provide details

Dashed box for vocational counselling.

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

No Yes

▶ Provide details

Dashed box for drug/alcohol use.

32. How long was or will the patient be

Totally disabled and unable to perform any part of their occupation

▶ From and including DD / MM / YYYY

To and including DD / MM / YYYY

Partially disabled and unable to perform some part of their occupation

▶ From and including DD / MM / YYYY

To and including DD / MM / YYYY

PLEASE SIGN DECLARATION - OVER PAGE

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" value="DD / MM / YYYY"/>
Address	<input type="text"/>	STAMP	
	<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. At the time of the accident, what were the gross weekly earnings (base rate of pay) excluding overtime and allowances
 Base hourly rate \$ Standard hours worked per week hours

11. Reason employee stopped working
 Illness Injury Other

12. Who is your Workcover insurer

13. Is the employee entitled to Workers' Compensation benefits
 No Yes ▶

Case Manager	Claim number
Phone	Email
RTW Coordinator	

ATTACH A COPY OF THE WORKCOVER CLAIM FORM

14. Do you contribute to another fund, which entitles the employee to make a claim for this injury
 No Yes ▶

Has a claim been made <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	Insurer
	Contact Name
	Phone

15. Was the worker employed at the time of the accident
 No Yes ▶

Address	Worksite
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16. When did the employee work for you

Commencement date Last day worked prior to the accident

17. Has the employee returned to work
 No Yes ▶

Date returned

18. Has the employee been made redundant
 No Yes ▶

Date

19. If employee was partially incapacitated (fit for light duties), would any sedentary (light/manual work or administration) work be available
 No Yes ▶

Provide details

20. Has the employee received any sick leave payments for this claim

No Yes

Number of days

The last date the employee was paid sick leave DD / MM / YYYY

21. How many sick leave days are owing

DD

PLEASE ATTACH ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY

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 DD / MM / YYYY

Total Claims Solutions Pty Ltd ABN 42 389 515 023
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