

ILLNESS CLAIM FORM

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

You have suffered an illness, **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 <input type="text"/>	2. Are you a union member <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Name of union <input type="text"/>	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"/> / <input type="text" value="MM"/> / <input type="text" value="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"/> cm	11. Weight <input type="text"/> kg	12. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Single
		13. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
14. Occupation <input type="text"/>		15. Do you require an interpreter <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Language <input type="text"/>

WORKER'S EMPLOYMENT DETAILS

16. Name of company <input type="text"/>	17. Phone <input type="text"/>
18. Date commenced <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="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 ▶ Have you been made redundant <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Date of termination <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	

PLEASE ATTACH A COPY OF YOUR LAST PAYSリップ

ILLNESS DETAILS

21. Date illness commenced <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	22. Date ceased work as a result of illness <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>
23. Have you returned to work <input type="checkbox"/> Yes ▶ Date returned to work <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/> <input type="checkbox"/> No ▶ Expected return date <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	

24. State in full detail, the illness(es) you are suffering from

25. Describe the symptoms that led you to seek medical advice

26. Do you believe your employment caused or significantly contributed to the development of your illness

☐ No

☐ Yes

Why do you believe your illness is work related

27. Have you submitted a claim to Workcover

☐ No

☐ Yes

Insurer

Case Manager

Claim number

Phone

28. Have you had a similar condition before

☐ No

☐ Yes

Doctor

Address

Phone

Date attended

DD

MM

YYYY

PHYSICIAN DETAILS

29. Details of the **first** physician, hospital or specialist attending to your illness

Doctor

Phone

Date attended

DD / MM / YYYY

Address

30. Details of **other** attending physicians

Doctor

1.

Phone

Date attended

DD / MM / YYYY

Address

Doctor

2.

Phone

Date attended

DD / MM / YYYY

Address

31. Who is your **usual** family doctor

Doctor

Phone

How long have you been a patient at this practice

YY / MM

Address

TREATMENT DETAILS

32. Are you receiving treatment for your illness

☐ No

☐ Yes

Provider

Type

Phone

Provider

Type

Phone

Provider

Type

Phone

MEDICAL AND CLAIMS HISTORY

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

Doctor

1.

Phone

Address

Treatment type

Date

DD / MM / YYYY

Doctor

2.

Phone

Address

Treatment type

Date

DD / MM / YYYY

34. Are you entitled to or making any other insurance or compensation claim for this illness

☐ 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

45. 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 (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

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, 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



ILLNESS CLAIM FORM

3 of 8

PATIENT DETAILS

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

1. Name

2. Age

3. Occupation

4. Address

ILLNESS DETAILS

5. What is the diagnosis causing the patient's incapacity

6. Date the patient was diagnosed with this illness

DD / MM / YYYY

7. What caused the patient's illness

8. Is this a psychological illness

☐ No ☐ Yes

▶ Describe the events that caused the illness and outline the clinical evidence to support the diagnosis

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

9. Please list any other illness(es) affecting the patient's incapacity

10. Date the patient first consulted you for this illness

DD / MM / YYYY

11. Date the patient last consulted you for this illness

DD / MM / YYYY

12. Has the patient attended further consultation for this illness or any related illness(es)

☐ No ☐ Yes

1.	DD / MM / YYYY	4.	DD / MM / YYYY
2.	DD / MM / YYYY	5.	DD / MM / YYYY
3.	DD / MM / YYYY	6.	DD / MM / YYYY

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

☐ No ☐ Yes

▶ Provide details

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

☐ No ☐ Yes

▶ Provide details

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

YY / MM

16. 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

TREATMENT DETAILS

17. 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

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

19. Have you provided any medical information to any other insurer regarding this illness

☐ No ☐ Yes ▶ Insurer

PLEASE PROVIDE MEDICAL REPORTS – IF ANY

20. Is the patient following your prescribed treatment?

☐ Yes ☐ No ▶ Provide details

21. Frequency of visits

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other

22. Has treatment been terminated

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

23. Is the patient still employed

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

CAPACITY FOR WORK

24. Are there any complications that may delay the recovery

☐ No ☐ Yes ▶ Provide details

25. What is your prognosis for recovery

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

☐ > 1 month ☐ 1–3 Months ☐ 4–6 months ☐ Other

27. 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

28. Would vocational counselling and/or retraining be recommended

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

30. 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"/>	<div>STAMP</div>	
	<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 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. 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 illness

☐ No ☐ Yes

Has a claim been made

☐ No ☐ Yes

Insurer

Contact name

Phone

15. Was the worker employed at the time of suffering the illness

☐ No ☐ Yes

Address

Worksite

16. When did the employee work for you

Commencement date

DD / MM / YYYY

Last day worked prior to the illness

DD / MM / YYYY

17. Has the employee returned to work

☐ No ☐ Yes

Date returned

DD / MM / YYYY

18. Has the employee been made redundant

☐ No ☐ Yes

Date

DD / MM / YYYY

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 ILLNESS

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