

# 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 <input type="text"/>	2. Are you a union member <input type="checkbox"/> No <input type="checkbox"/> Yes <span style="margin-left: 10px;">▶ Name of union <input type="text"/></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"/> / <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 <span style="margin-left: 10px;">▶ Language <input type="text"/></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"/> / <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 <span style="margin-left: 10px;">▶ Date of termination <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/></span>	

**PLEASE ATTACH A COPY OF YOUR LAST PAYSリップ**

## 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](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

**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, 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



**QBE**

## 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) &amp; 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

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