Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

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, capital and/or broken bones benefits under the 'Outside Working Hours – Injury/Journey' insurance program.

FORWARD THIS CLAIM FORM TO

Total Claims Solutions
Level 1, 151 Rathdowne Street
Carlton VIC 3053

FOR CLAIM ENQUIRIES CALL

Total Claims Solutions
(03) 9320 8588

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

- ☐ Proof of dependant(s) – *if any*
- ☐ Payslip
- ☐ Radiologists report(s)
- ☐ 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. Incolink member number

2. Are you a union member ☐ No ☐ Yes ▶ Name of union

3. Given name(s) | Surname

4. Date of birth DD / MM / YYYY

5. Address (no PO Box)

6. Home phone | **7.** Mobile | **8.** Email

9. Height cm | **10.** Weight kg | **11.** Marital status ☐ Married ☐ Defacto ☐ Single | **12.** Sex ☐ Male ☐ Female

13. Occupation

14. Do you require an interpreter ☐ No ☐ Yes ▶ Language

DEPENDANTS DETAILS

15. Do you have dependants

☐ No ☐ Yes ▶ Given name(s) | Surname

Date of birth DD / MM / YYYY

Dependants means;
The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months) whose gross earnings are less than $18,200 in the 12 months immediately prior to the date of injury, or the unmarried financially dependant children of the worker up to 16 years of age or up to 25 years of age if a full time student.

Status of dependant(s)

- ☐ **Spouse** – Attach a copy of spouse's tax return or documentation to support earned income.
- ☐ **Child under 16** – Attach a copy of the child's birth certificate or Medicare card listing the child.
- ☐ **Student over 16** – Attach a copy of the student's ID card.

PLEASE ATTACH PROOF OF DEPENDANT(S)

WORKER'S EMPLOYMENT DETAILS

16. Name of company | **17.** Phone

18. Date commenced DD / MM / YYYY

19. Employment status ☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ 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

IF CLAIMING FOR BROKEN BONES, PLEASE SUPPLY A COPY OF THE RADIOLOGISTS REPORT

26. Where did the accident occur

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

27. Was an ambulance called

☐ Yes ☐ No

28. Address where accident occurred

29. Name of witness(es) Phone

1.

2.

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

☐ No ☐ Yes ▶ Why do you believe your injury is work related

31. Have you submitted a claim to Workcover

☐ No ☐ Yes ▶ Insurer Claim number

Case Manager Phone

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

☐ No ☐ Yes ▶ Location 1 Amount

Location 2 Amount

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

☐ No ☐ Yes ▶ Club name Phone

34. Have you had a similar condition before

☐ No ☐ Yes ▶ Doctor Phone

Address Date attended DD / MM / YYYY

PHYSICIAN DETAILS

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

Doctor Phone Date attended DD / MM / YYYY

Address

36. Details of **other** attending physicians

Doctor 1. Phone Date attended DD / MM / YYYY

Address

Doctor 2. Phone Date attended DD / MM / YYYY

Address

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

Doctor Phone How long have you been a patient at this practice YY / MM

Address

TREATMENT DETAILS

38. Are you receiving treatment for your injury

☐ No ☐ Yes ▶

Provider	Provider	Provider
Type	Type	Type
Phone	Phone	Phone

MEDICAL AND CLAIMS HISTORY

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

Treatment type	1.	Treatment type	2.
Doctor		Doctor	
Phone		Phone	
Date	DD / MM / YYYY	Date	DD / MM / YYYY

40. 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

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

☐ Cheque ☐ Electronic Funds Transfer ▶

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

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

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 my 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 my credit or insurance history as well as insurance claims information obtained during the course of this contract.

I agree for Incolink to supply details of my employer payments to assist with my claim.

I authorise QBE Insurance (Australia) Limited or its representative to refer my claim to Incolink's Member Service Department, 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 — Physician/Treating Doctor

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 DD / MM / YYYY

7. Date the patient first consulted you for this injury DD / MM / YYYY

8. Date the patient last consulted you for this injury DD / MM / YYYY

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

☐ No ☐ Yes ▶ Provide details

12. Did the patient sustain the injury at work

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details and include BAC reading if taken

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

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

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

☐ No ☐ Yes ▶ Insurer

PLEASE PROVIDE MEDICAL REPORT(S) – IF ANY

22. Is the patient following your prescribed treatment

☐ Yes ☐ No ▶ Provide details

23. Frequency of visits

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other

24. Has treatment been terminated

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

25. Is the patient still employed

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

CAPACITY FOR WORK

26. Are there any complications that may delay the recovery

☐ No ☐ Yes ▶ Provide details

27. What is your prognosis for recovery

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

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

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

30. Would vocational counselling and/or retraining be recommended

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

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		Medical qualifications	
Signature		Date	DD / MM / YYYY
Address			STAMP
Phone			
Fax			
Email			

Section C Employer

EMPLOYER DETAILS

1. Business/trading name

2. 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 ☐ Apprentice ☐ 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 ☐ No ☐ Yes ▶ Insurer

Contact name

Phone

15. Was the worker employed at the time of the accident

☐ No ☐ Yes ▶ Address | Worksite

16. When did the employee work for you

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