

EMERGENCY TRANSPORT CLAIM FORM

Emergency Ambulance Cover is provided via Incolink's Discretionary Fund and is governed by the Discretionary Guidelines

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

An ambulance has been used within Australia. Incolink guidelines will be followed when assessing this claim.

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

Claim Form

The **WORKER** must complete ALL questions on pages 1 and 2 of the form once the Ambulance invoice has been received.

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

This claim must be supported by proof of identity.

Acceptable Documents

1. A current Australian drivers license, or
2. A current Australian passport

IMPORTANT

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

CHECKLIST

- Proof of dependant(s)
- Original ambulance invoice
- Proof of identity

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. Street Address (no PO Box) Suburb Postcode

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

CLAIMANT DETAILS

15. Person claiming
 Worker Spouse/Defacto/Child Defacto – Attach a copy of at least one bill confirming the same residence.
 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.

Dependants means;
 The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months), 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.

16. Name of person claiming (if not worker)

17. Date of birth DD / MM / YYYY

PLEASE ATTACH DOCUMENTATION

WORKER'S EMPLOYMENT DETAILS

18. Name of company

19. Phone

20. Date commenced DD / MM / YYYY

21. Employment status
 Full-time Part-time Casual Apprentice Working Director Sub-Contractor

22. Are you still employed?

Yes No ▶ Date of termination DD / MM / YYYY

OTHER BENEFIT DETAILS

The Incolink Emergency Transport Program requires all ambulance claims to be lodged via the relevant Australian ambulance service or your private health insurer in the first instance.

23. Are you a Pension or Health Care card holder?

No Yes ▶ Card number

24. Do you have private health insurance?

No Yes ▶ Name of health fund Membership number
Is Ambulance cover included? No Yes ▶ You must submit the claim to your private health fund

AMBULANCE DETAILS

25. Date ambulance required 26. Exact time ambulance required

DD / MM / YYYY HH : MM am / pm

27. Detail why an ambulance was required

[Empty text box for ambulance details]

PLEASE ATTACH ORIGINAL AMBULANCE INVOICE

28. Was the ambulance required as a result of a motor vehicle accident?

No Yes ▶ You must submit the claim to the appropriate statutory scheme

29. Was the ambulance required as a result of a work accident?

No Yes ▶ You must submit the claim to the appropriate statutory scheme

PAYMENT DETAILS

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

Pay funds directly to Ambulance service
 Forward a cheque payable to myself
 Electronic Funds Transfer to myself ▶ Please provide your banking details.
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 Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.
Signature Date DD / MM / YYYY

DECLARATION AND AUTHORISATION

I hereby authorise any Australian Ambulance Service or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim.

I authorise Total Claims Solutions to give or obtain information relating to my claim from any insurer and/or private health fund, statutory authorities, or their representatives.

I authorise Total Claims Solutions to give or obtain information to my employer.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I understand that supplying false or misleading information will result in my right to compensation being forfeited.

I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

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.

Signature [Text Box]
Print name [Text Box]
Date DD / MM / YYYY

Total Claims Solutions manage the Discretionary Ambulance Claims on behalf of Incolink



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Acting as Claims Managers on behalf of Incolink
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