



ACCIDENT & ILLNESS CLAIM FORM

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

You have suffered an accident/illness that prevents you from working.

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

FORWARD THIS CLAIM FORM TO

Total Claims SolutionsGround Floor, 56 Harris Street

Pyrmont NSW 2009

claimsNSW@totalclaims.com.au

FOR CLAIM ENQUIRIES CALL

Total Claims Solutions (02) 8732 8555

INSTRUCTIONS

This claim must be supported by proof of identity.

Acceptable Documents

A current Australian drivers license, or
 A current Australian passport

Section A

The **WORKER** must complete ALL questions in Section A of this claim form and the attached Tax File Number Declaration form.

Section B

The worker's **ATTENDING PHYSICIAN** must complete Section B 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 of this form.

IMPORTANT

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

CHECKLIST

- Copies of Medical report(s) if any
- Hospital Discharge
 - Summaries *if any*
- Radiologists report(s)
- Job description
- Workcover claim form and and payment advices relating to the claimed condition if relevant
- Medical certificate(s)
- Tax File Number Declaration
- Proof of identity
- Proof of bank details

The issue of this form **DOES NOT** constitute admission of liability on our behalf.

Section A WORKER WORKER DETAILS 1. PPTEF member number Are you a union member No ☐ Yes ► Name of union 3. Given name(s) Surname Date of birth DD / MM / YYYY Residential Address (no PO Box) 6. Home phone 7. Mobile Email Height 10. Weight 11. Marital status **12.** Sex cm kg ☐ Married ☐ Defacto ☐ Single Male Female 13. Occupation 14. Do you require an interpreter No Yes Language **EMPLOYMENT DETAILS** 15. Name of employer Site address Occupation 18. Employment status Full-time Part-time Casual Apprentice Working Director Sub-Contractor

19. Please list yo List duties	ur usual duties and pe	rcentage of	time spent	on each task			% time sper	nt on task	
ACCIDENT AL	ND ILLNESS DETAI	15							
	ning due to injury or sic								
Injury	Date of injury Time of injury	DD /	M M / Y	YYY m/pm	Illness	Date of illness D	D / MM / Y	YYY	
21. Please descri	ibe your injury or sickn	ess.							
22. What is the d	ate that you first cease	d work due	to this injur	ry/sickness	23. How long do	you anticipate you will be av	way from work as	a result of t	his condition
24. If you have al	lready returned to worl	k, please sp	ecify the da	ite	25. Do you have	private health insurance			
DD / MM	/ YYYY				☐ No ☐ Yes	Please advise fund			
26. Have you eve	er had a similar condition	on in the pa	st. If Yes, pl	ease give deta	ails and specify the	dates you received treatment	t 		
No Yes	Date attended D	D / M M	/ YYY	Υ	Doctor				
	Clinic/hospital	========	:=======	========	Phone		Usual doctor	No	Yes
	Date attended D	D / MM	/ YYY	Υ	Doctor				
	Clinic/hospital				Phone		Usual doctor	☐ No ☐] Yes
	Date attended D	D / MM	/ YYY	Υ	Doctor				
	Clinic/hospital				Phone		Usual doctor	No [Yes
27. Other insurar	nce. In respect of this in	njury or sick	ness are yo	u receiving or	planning to lodge a	ı claim against			
Motor accident com	npensation benefit	☐ No	Yes	Insurer		Claim number	Phone		
Worker's compensa	ation benefit (WorkCover) No	Yes	Insurer		Claim number	Phone	:======	
Sports insurance w	ith club	☐ No	Yes	Insurer		Claim number	Phone	;======:	
Any other insurance	e policy for loss of wage	s No	☐ Yes ▶	Insurer	=======================================	Claim number	Phone	:======:	=======
				L	COE ANY CLAIM			CATEC	
II.	r applicable, ple					CORRESPONDENCE, ME AIMED INJURY/ILLNESS.	DICAL CERTIFIC	CATES	
PLEASE COM	IPLETE THE QUEST	IONS BEL	OW ONLY	/ IF YOU AR	RE CLAIMING FO	R AN INJURY			
	/ how the accident occ								
,			<u> </u>		<u>. </u>				
29. Where did the	e accident occur					30. Have you so	ubmitted a claim t	to Workcove	 !r
Home Wo	rk Travelling to/fro	m work	Other			Yes No			
31. Address whe	re accident occurred						Postcode		
32. Name of with	ness(es)					Relationship	Phone		
1.									
2									

Location 2	33. Had you consu	umed any alcohol or drugs in t Location 1	ne 8 hours prior to the accident	it Amount				
34. Did the excident occur while training for or playing soort 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 membrashies that it relevant to use, administer and manage products and provide services. You can view our Privacy Policy as tww. obe. com. auditivecy, or to obtain a copy by phoning us on 133.723 or requested in the manage products and provide services. You can view our Privacy Policy as tww. obe. com. auditivecy or to obtain a copy by phoning us on 133.723 or requested in service providers. We may share you information on the red Se 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 as collecting, disclosing, storing and using it accordance with our Privacy Policy it, you glose has someone exists? personal information in your consent to do so. If you don't provide all the personal information we've requested we may be unable to issue, administer or manage products or provide services. If you have been informed by us that your claim has been accepted for weekly benefits and we have received your fax File Number Declaration, we will provide payment and of any withholding RNG fax which will be payable to the XID. If you do not return the completed tax file number declaration to us within 28 days of a accepting your claim, we will be required to withhold tax at the top marginal tax rate on any payments we make to you. Any tax withheld by OBE will reduce your tiability at the end of the financial year. PAYMENT DEPETALIS 35. If this claim is accepted, how would you like to receive payment [5] Cheque Electronic Funds Transfer Bank same Account number Bank same Account number Bank same Bank same Account number Bank same Accou								
Duty Privacy Our Privacy Policy describes how we collect, discloses, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information, criminal history or professional memberofusips that's relevant to us issuin 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 provides services. Voice an well our Privacy Policy at two well do these things. We use personal information to issue, administer and manage products and provides services. Voice an well were privacy Policy at two well, on the term of the provides of the provides of the provides of the provides of the privacy Policy II you give us someone desk's personal information with other DBE Corup companies, our authorised representatives and accordance with our Privacy Policy, II you give us someone desk's personal information, you consent to us collecting, disclosing and using it accordance with our Privacy Policy, II you give us someone desk's personal information, you consent to us collecting, disclosing and using it accordance with our Privacy Policy, II you give us someone desk's personal information, you confirm you've obtained their consent to do so. If you do not return the provides and the personal information were required we may be unable to issue, administer or manage products or provide services. If you have been informed by us that your claim has been accepted for weekly benefits and we have received your Tax FIR Number Declaration, we will be required to withhold tax at the top marginal tax rate on any payments, we make a consultation to us within 28 days of unaccepting your claim, we will be required to withhold tax at the top marginal tax rate on any payments, we make to you. Any tax withheld by OBE will reduce your triability at the end of the financial year. **PAYMENT DECLARATION** **PAYMENT DECLARATION** **DECLARATION** **DECLARATION** **DECLARATION*	24 Did the asside	1		Amount				
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 is, health information, criminal history or professional memberships that's relevant to us issuing administer on or managing products or providing services or provides and provide services. You can view our Privacy Policy at www.qbe.com.au/privacy, of to obtain a copy by pholing us on 150 725 or requesting in the more authorised representatives and a service provides. Such of which may be based outside of Autrealia, by giving us personal information, you consent to us collecting, disclosing, storing and using it accessed to the provider of t			iaying sport	Phone				
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 issuina administer not managing products or providing services of providing services or provided services. You can view our Privacy Policy at waw.qbc.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requesting in the non use without provided services. You was used to do a distration at the provided services or provided services or provided services or provided services. **TAK FILE NUMBER DECLARATION** If you have been informed by us that your claim has been accepted for weekly benefits and we have received your Tax File Number Declaration, we will provide payment net of any withholding PXYG tax which will be payable to the ATO. If you do not return the completed tax file number declaration to us within 28 days of us accepting your claim, we will be required to withhold tax at the top marginal tax rate on any payments we make to you. Any tax withheld by GBE will reduce your tiability at the end of the financial year. **PXYMENT DETAILS** 35. If this claims is accepted, how would you like to receive payment (s) **Cheque** **DEASE ATTACH PROOF OF BANK DETAILS** FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT** **DECLARATION AND AUTHORISATION BY PERSON CLAIMING** **DEASE ATTACH PROOF OF BANK DETAILS** FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT** **DECLARATION AND AUTHORISATION BY PERSON CLAIMING** **Declaration of the properties of injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records: a longer of the solid claim and copies of all hospital or medical records: a longer of the solid claim and a properties or injury, medical hist		Old Hame		11000				
personal information, we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuin administering or managing products or providing services or providing services provided services. You can view our Privacy Policy IV you give us some one else's personal information or work or provides services. **TAY FILE NUMBER DECLARATION** **TAY FILE NUMBER DECLARATION** **Tay On the ve requested we may be unable to issue, administer or manage products or provide services. **TAY FILE NUMBER DECLARATION** **Tay On the very services or service provided services.** **TAY FILE NUMBER DECLARATION** **Tay On the very services or services or services or services.** **TAY FILE NUMBER DECLARATION** **Tay On the very services or services or services.** **TAY FILE NUMBER DECLARATION** **Tay On the very services or services.** **TAY FILE NUMBER DECLARATION** **Tay On the very services or services.** **TAY FILE NUMBER DECLARATION** **Tay On the very services or services.** **TAY FILE NUMBER DECLARATION** **TAY ON THE NUMBER DECLARATION** **TAY OF THE NUMBER DECLARATI								
If you have been informed by us that your claim has been accepted for weekly benefits and we have received your Tax File Number Declaration, we will provide payment net of any withholding PAYG tax which will be payable to the ATO. If you do not return the completed tax file number declaration to us within 28 days of us accepting your claim, we will be required to withhold tax at the top marginal tax rate on any payments we make to you. Any tax withheld by QBE will reduce your triability at the end of the financial year. PAYMENT DETAILS 3. If this claim is accepted, how would you like to receive payment (s) Cheque Electronic Funds Transfer Medapand on the accuracy of the details you provide. Please attach proof of - Account name - SSB // Account name - Account name	personal information administering or material manage products at it from our authorist service providers, eaccordance with out the personal information.	on, we may also mean sensitive anaging products or providing nd provide services. You can ved representatives or service peach of which may be based or ar Privacy Policy. If you give us nation we've requested we ma	e information such as health inf services and the terms on whic iew our Privacy Policy at www. providers. We may share your in utside of Australia. By giving us someone else's personal inforr	formation, criminal history or professional memberships that's relevant to ch we will do these things. We use personal information to issue, adminisgorable.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requinformation with other QBE Group companies, our authorised representations personal information, you consent to us collecting, disclosing, storing an mation you confirm you've obtained their consent to do so. If you don't put	us issuing, iter and uesting ives and ind using it in			
payment net of any withholding PAYG tax which will be payable to the ATO. If you do not return the completed tax file number declaration to us within 28 days of us accepting your claim. we will be required to withhold tax at the top marginal tax rate on any payments we make to you. Any tax withheld by QBE will reduce your triability at the end of the financial year. PAYMENT DETAILS 35. If this claim is accepted, how would you like to receive payment (s) Cheque Electronic Funds Transfer	TAX FILE NUM	IBER DECLARATION						
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I authorise any hospital, physician or other person who has attended me, or any employer, to give QBE Insurance (Australia) Ltd 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 the copies of all employer records relevant to my claim including verification of earnings can be provided. I give permission for QBE Insurance (Australia) Ltd or its representatives, to give to and obtain from other insurers and/or statutory authorities, or their representatives, insurance reference bureaus ar credit reporting agencies any information relating to my credit or insurance history as well as insurance claims information obtained during the course of this control agree for Plumbing & Pipe Trades Entitlement Fund to supply details of my employment contributions to assist with my claim. I understand that Total Claims Solutions Pty Ltd act as claims managers on behalf of QBE Insurance (Australia) Ltd. A photocopy of this authorisation will be conside as effective and valid as the original. I do solemnly and sincerely declare that the information I have provided is true and correct in every detail and I agree that if I have made or in further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused 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 Date DD / MM / YYYY AEN 083 775 79 AFSL No. 230747. Acting as Claims Manager on behalf of QBE Insurance (Australia) Limited ABN 78 003 191035.			Signature	Date DD / MM / YYYY				
I authorise any hospital, physician or other person who has attended me, or any employer, to give QBE Insurance (Australia) Ltd 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 the copies of all employer records relevant to my claim including verification of earnings can be provided. I give permission for QBE Insurance (Australia) Ltd or its representatives, to give to and obtain from other insurers and/or statutory authorities, or their representatives, insurance reference bureaus ar credit reporting agencies any information relating to my credit or insurance history as well as insurance claims information obtained during the course of this control agree for Plumbing & Pipe Trades Entitlement Fund to supply details of my employment contributions to assist with my claim. I understand that Total Claims Solutions Pty Ltd act as claims managers on behalf of QBE Insurance (Australia) Ltd. A photocopy of this authorisation will be conside as effective and valid as the original. I do solemnly and sincerely declare that the information I have provided is true and correct in every detail and I agree that if I have made or in further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused 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 Date DD / MM / YYYY AEN 083 775 79 AFSL No. 230747. Acting as Claims Manager on behalf of QBE Insurance (Australia) Limited ABN 78 003 191035.		PLEASE ATTACH P	ROOF OF BANK DETAILS -	- FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT				
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totalclaims.com.au T76.01062024_	No. 001294613 of Windsor Management Insurance Brokers AFSL No. 230747. Acting as Claims Manager on behalf of QBE							
				totalclaims.com.au T76.0)1062024_NSW			

	Section B	111151517	N/TREATING DOCTOR			
F	PATIENT DETAILS					
	THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT					
1.	Given name(s)	Surname	2. Date of birth			
			DD / MM / YYYY			
 3.	Address (no PO Box)					
1	MEDICAL DETAILS					
4.	On what date did you first consult the patient in relation to t	his condition				
	DD / MM / YYYY					
5.	What is the diagnosis which has led to the patient's disabler	ment				
6.	What investigations have been undertaken in determining a	diagnosis				
7.	Date of diagnosis					
	DD / MM / YYYY					
8.	Is the patient's diagnosis an injury, resulting from an accider	nt or an Illness, sickness or disease. Please advise				
 9.	If the patient's diagnosis is as a result of an injury please ad	vise the circumstances of the patient's accident and where it occur	red			
		,				
10	Date of patient's injury					
	DD / MM / YYYY					
11.	What caused the patients injury/illness					
42						
	Is the patients injury/illness relating to a motor accident com	npensation claim	,			
_	No Yes Provide details					
13. Has the patient's employment caused or significantly contributed to, aggravated, accelerated, exacerbated or deteriorated the condition causing the patient current disablement						
	No Yes Provide details					
	Was the patient training for or playing sport at the time of th	neir accident				
	☐ No ☐ Yes ▶ Provide details					
15. Did the use of alcohol and/or drugs directly or indirectly contribute to the patient's injury/illness						
No ☐ Yes ▶ Provide details and include BAC reading if taken						
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 disablement						
	ļ					
17	Have you provided any modical information to any other inc	curer regarding this injury/illness				
17. Have you provided any medical information to any other insurer regarding this injury/illness. No Yes Provide copies of reports and details of insurer						
i I	THO I LIES . I LOVING CODIES OF IEDOLIS GITH HERBIS OF III.	Juici				

PLEASE PROVIDE MEDICAL REPORT(S) - IF ANY

TREATMENT DETAILS					
19. Has the patient been hospitalised					
No ☐ Yes ► From DD / MM / YYYY To DD / MM / YYY	YY Date treatment prescribed DD / MM / YYYY				
Name of hospital	Phone				
20. Provide full details of treatment prescribed and the results including any surgery or med	dication				
22. Is the patient following your prescribed treatment					
Yes No Provide details					
23. Frequency of visits	24. Has treatment been terminated				
Weekly Fortnightly Monthly Other	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					
No ☐ Yes ► Provide details					
27. W					
27. What is your prognosis for recovery					
20. What is the appropriated time from a few years your and watering to full time your					
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					
,	ns ceased DD / MM / YYYY				
Explain the specific restrictions and limitations including hours per day/we					
Explain the specific restrictions and limitations including flours per day, we	: C K				
20 W II					
30. Would vocational counselling and/or retraining be recommended No Yes ► Provide details					
No ☐ Yes ► Provide details					
24. In the use of drugs and/or algebra effecting the national ability to receive and return to	nowle				
31. Is the use of drugs and/or alcohol affecting the patient's ability to recover and return to No Yes Provide details	WUIK				
110 les 110vide détails					
32. How long was or will the patient be					
	nd including DD / MM / YYYY				
Partially disabled and unable to perform some part of their occupation From and including DD / MM / YYYYY					
To and	including DD / MM / YYYY				
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 qual	lifications				
Signature	Date DD / MM / YYYY				
Address	CTAMP				
Address	STAMP				
Phone					
Fax					
Email					

Section C **EMPLOYER** Business/trading name Employer number Address Phone **5.** Fax 6. Email **DETAILS OF EMPLOYEE MAKING CLAIM** Name Job classification/occupation 8. ATTACH EMPLOYEE'S JOB DESCRIPTION Date the employee commenced working for the company 10. Employment status ☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ Working Director ☐ Sub-Contractor DD / MM / YYYY Gross Earnings for the last 12 months prior to injury/illness 12. Number of weeks worked in the last 12 months \$ weeks ATTACH EMPLOYEE'S PAYROLL HISTORY 13. Reason employee stopped working Illness Injury Other 14. In respect of this injury or sickness has the employee lodged a worker's compensation benefit (WorkCover) No ☐ Yes ► Insurer Claim number Phone PLEASE PROVIDE COPIES OF ALL WORKCOVER DOCUMENTS RELATING TO THIS CLAIM **15.** Date the employee last worked **16.** Has the employee returned to work No Yes ▶ Date returned DD / MM / YYYY DD / MM / YYYY 17. Has the employee been terminated from the company No ☐ Yes ▶ Date DD / MM / YYYY Reason 18. Has the employee received any sick leave payments for this claim The last date the employee was paid sick leave DD / MM / YYYY 19. How many sick leave days are owing PLEASE ATTACH ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY 20. If employee was partially incapacitated (fit for light duties), would any sedentary (light/manual work or administration) work be available ☐ No ☐ Yes ► Provide details **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