Total Claims SOLUTIONS

Incolink Entitlements Insurance Wellbeing

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 Solutions
Ground Floor, 56 Harris Street
Pyrmont NSW 2009

Or email:
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
1. A current Australian drivers license, or
2. 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. 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. Residential 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

EMPLOYMENT DETAILS

15. Name of employer

16. Site address

17. Occupation

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

19. Please list your usual duties and percentage of time spent on each task

List duties	% time spent on task

ACCIDENT AND ILLNESS DETAILS

20. Are you claiming due to injury or sickness

☐ Injury ▶ Date of injury DD / MM / YYYY
Time of injury HH : MM am / pm

☐ Illness ▶ Date of illness DD / MM / YYYY

21. Please describe your injury or sickness.

22. What is the date that you first ceased work due to this injury/sickness

DD / MM / YYYY

23. How long do you anticipate you will be away from work as a result of this condition

24. If you have already returned to work, please specify the date

DD / MM / YYYY

25. Do you have private health insurance

☐ No ☐ Yes ▶ Please advise fund

26. Have you ever had a similar condition in the past. If Yes, please give details and specify the dates you received treatment

☐ No ☐ Yes ▶

Date attended DD / MM / YYYY Doctor
Clinic/hospital Phone Usual doctor ☐ No ☐ Yes

Date attended DD / MM / YYYY Doctor
Clinic/hospital Phone Usual doctor ☐ No ☐ Yes

Date attended DD / MM / YYYY Doctor
Clinic/hospital Phone Usual doctor ☐ No ☐ Yes

27. Other insurance. In respect of this injury or sickness are you receiving or planning to lodge a claim against

Motor accident compensation benefit	☐ No	☐ Yes ▶	Insurer	Claim number	Phone
Worker's compensation benefit (WorkCover)	☐ No	☐ Yes ▶	Insurer	Claim number	Phone
Sports insurance with club	☐ No	☐ Yes ▶	Insurer	Claim number	Phone
Any other insurance policy for loss of wages	☐ No	☐ Yes ▶	Insurer	Claim number	Phone

IF APPLICABLE, PLEASE ATTACH COPIES OF COPIES OF ANY CLAIM CORRESPONDENCE, MEDICAL CERTIFICATES AND PAYMENT ADVICES RELATING TO THE CLAIMED INJURY/ILLNESS.

PLEASE COMPLETE THE QUESTIONS BELOW ONLY IF YOU ARE CLAIMING FOR AN INJURY

28. Detail exactly how the accident occurred including what you were doing prior to the accident

29. Where did the accident occur

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

30. Have you submitted a claim to Workcover

☐ Yes ☐ No

31. Address where accident occurred — Postcode

32. Name of witness(es) — Relationship — Phone

1.

2.

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

☐ No ☐ Yes ▶

Location 1	Amount
Location 2	Amount

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

☐ No ☐ Yes ▶

Club name	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.

TAX 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 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 tax liability 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 ▶

We depend on the accuracy of the details you provide.

Please attach proof of
- Account name
- BSB / Account number

to ensure correct details are entered for payment

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

PLEASE ATTACH PROOF OF BANK DETAILS – FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT

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) 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 that 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 representative to obtain a copy of any police report with respect to my claim. I authorise 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 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 employment contributions to assist with my claim. Authorise QBE Insurance (Australia) Ltd or its representative to refer my claim to Incolink's Member Service Department (if required).

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 considered 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

Print name

Date DD / MM / YYYY

QBE Total Claims SOLUTIONS

Total Claims Solutions Pty Ltd ACN 131 362 671 is an Authorised Representative No. 001294613 of Windsor Management Insurance Brokers Pty Ltd ACN 083 775 795 AFSL No. 230747. Acting as Claims Manager on behalf of QBE Insurance (Australia) Limited ABN 78 003 191 035.

totalclaims.com.au

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Section B PHYSICIAN/TREATING DOCTOR

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)

MEDICAL DETAILS

4. On what date did you first consult the patient in relation to this condition

DD / MM / YYYY

5. What is the diagnosis which has led to the patient's disablement

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 accident or an Illness, sickness or disease. Please advise

9. If the patient's diagnosis is as a result of an injury please advise the circumstances of the patient's accident and where it occurred

10. Date of patient's injury

DD / MM / YYYY

11. What caused the patients injury/illness

12. Is the patients injury/illness relating to a motor accident compensation 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

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

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

PLEASE PROVIDE MEDICAL REPORT(S) – IF ANY

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

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

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

Phone

Fax

Email

STAMP

Section C EMPLOYER

EMPLOYER DETAILS

1. Business/trading name

2. Employer number

3. Address

4. Phone

5. Fax

6. Email

DETAILS OF EMPLOYEE MAKING CLAIM

7. Name

8. Job classification/occupation. Please attach the employees job description

9. Date the employee commenced working for the company

DD / MM / YYYY

10. Employment status

☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ Working Director ☐ Sub-Contractor

11. Payroll history

Please attach a 26 weeks payroll history substantiating the employees average weekly earnings prior to ceasing work as a result of the injury/Illness.
Payroll history needs to be broken up and productivity allowance and overtime payments to be included.

12. Reason employee stopped working

☐ Illness ☐ Injury ☐ Other

13. 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

14. Date the employee last worked

DD / MM / YYYY

15. Has the employee returned to work

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

16. Has the employee been terminated from the company

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

17. 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

18. How many sick leave days are owing

DD

PLEASE ATTACH ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY

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

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