Total Claims SOLUTIONS

Incolink Entitlements Insurance Wellbeing

WORKCOVER TOP-UP CLAIM FORM

OFFICE USE ONLY | Claim number | Reference

COMPLETE THIS FORM IF

You have suffered a workplace accident and have received 52 weeks of Workcover benefits and wish to claim top-up benefits

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

FORWARD THIS CLAIM FORM TO

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

Or email:
claimsVIC@totalclaims.com.au

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 and the attached **Tax File Number Declaration** form.

This claim must be supported by proof of identity.

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

Section B

The worker's **ATTENDING PHYSICIAN** must complete Section B (pages 4–5) 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 (page 6) of this form.

IMPORTANT

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

CHECKLIST

- ☐ Payslip(s) or Remittances(s) from 53rd week
- ☐ Workcover claim form – *copy*
- ☐ Workcover acceptance letter
- ☐ 52 week reduction letter – *if issued*
- ☐ Medical report(s) – *if any*
- ☐ Job description
- ☐ 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. 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

WORKER'S EMPLOYMENT DETAILS

15. Name of company

16. Phone

17. Date commenced DD / MM / YYYY

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

19. Are you still employed ☐ Yes ☐ No ▶ Have you been made redundant ☐ No ☐ Yes ▶ Date of termination DD / MM / YYYY

FROM THE 53RD WEEK OF WORK COVER BENEFITS PLEASE ATTACH PAYSLIP(S) OR PAYMENT/REMITTANCE STATEMENT(S) IF WORKCOVER IS PAYING YOU DIRECT

ACCIDENT DETAILS

20. Date of accident DD / MM / YYYY

21. Date ceased work as a result of accident DD / MM / YYYY

22. Have you returned to work

☐ Yes ▶ Date returned to work DD / MM / YYYY ☐ No ▶ Expected return date DD / MM / YYYY

23. Describe your injury

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

WORKCOVER DETAILS

PLEASE ATTACH A COPY OF THE WORKCOVER CLAIM FORM & WORKCOVER ACCEPTANCE LETTER

25. Workcover insurer

Name | Claim number

26. Workcover case manager

Name | Phone | Fax

Email

PLEASE ATTACH A COPY OF THE 52 WEEK REDUCTION LETTER –IF ISSUED

PHYSICIAN DETAILS

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

Doctor | Phone | Date attended DD / MM / YYYY

Address

28. Details of **other** attending physicians

Doctor 1. | Phone | Date attended DD / MM / YYYY

Address

Doctor 2. | Phone | Date attended DD / MM / YYYY

Address

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

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

Address

TREATMENT DETAILS

30. Are you receiving treatment for your injury

☐ No ☐ Yes ▶

Provider | Phone

Type

Provider | Phone

Type

Provider | Phone

Type

MEDICAL AND CLAIMS HISTORY

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

Date	Treatment	Name of Doctor/Hospital	Phone
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			

32. Are you entitled to or making any other insurance or compensation claim for this accident

☐ Motor Compensation ☐ Private Health Fund ☐ Superannuation Life Insurance ☐ Income Protection ☐ Travel ☐ 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.

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

33. 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 understand that Total Claims Solutions Pty Ltd act as claims managers on behalf of QBE Insurance (Australia) Ltd. 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 employer payments to assist with my claim. I authorise QBE Insurance (Australia) Ltd or its representative to refer my claim to Incolink's Member Service Department (if required).

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 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

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.

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. Are there any other conditions impacting on the patient's incapacity

☐ No ☐ Yes ▶ Provide details

11. 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

12. How long have you known the patient in a professional capacity YY / MM

TREATMENT DETAILS

13. 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

14. Provide full details of treatment prescribed and the results including any surgery or medication

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

☐ No ☐ Yes ▶ Insurer

PLEASE PROVIDE MEDICAL REPORT(S) – IF ANY

16. Is the patient following your prescribed treatment

☐ Yes ☐ No ▶ Provide details

17. Frequency of visits

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other

18. Has treatment been terminated

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

CAPACITY FOR WORK

19. Are there any complications that may delay the recovery

☐ No ☐ Yes ▶ Provide details

20. What is your prognosis for recovery

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

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

22. 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

23. Would vocational counselling and/or retraining be recommended

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

25. Is the patient still employed

☐ Yes ☐ No ▶ Termination / redundancy date 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

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. Has the employee returned to work

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

11. Has the employee been made redundant

☐ No ☐ Yes

12. If the employee is fit for suitable or alternative duties, would you be able to offer such duties

☐ No ☐ Yes ▶ Describe duties

WORK INJURY MANAGEMENT SERVICE

The Work Injury Management Service is available at no additional cost for employers who participate in Incolink's IPT program. An Injury Management Coordinator will contact you to discuss the benefits of this service.

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