

ILLNESS CLAIM FORM

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

You have suffered an illness, **outside working hours** and wish to claim weekly benefits, under the "Outside Working Hours – Illness" 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
- 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

3. Given name(s) Surname

4. Date of birth

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

DEPENDANTS DETAILS

15. Do you have dependants
 No Yes

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

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 PAYSリップ

ILLNESS DETAILS

21. Date illness commenced 22. Date ceased work as a result of illness

DD / MM / YYYY DD / MM / YYYY

23. Have you returned to work

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

24. State in full detail, the illness(es) you are suffering from

[Empty text box for illness details]

25. Describe the symptoms that led you to seek medical advice

[Empty text box for symptoms]

26. Was an ambulance called

Yes No

27. Do you believe your employment caused or significantly contributed to the development of your illness

No Yes ▶ Why do you believe your illness is work related

[Dashed box for explanation of work-related illness]

28. Have you submitted a claim to Workcover

No Yes ▶ Insurer Claim number
Case Manager Phone

29. Have you had a similar condition before

No Yes ▶ Doctor Phone
Address Date attended DD / MM / YYYY

PHYSICIAN DETAILS

30. Details of the **first** physician, hospital or specialist attending to your illness

Doctor [] Phone [] Date attended DD / MM / YYYY
Address []

31. Details of **other** attending physicians

Doctor 1. [] Phone [] Date attended DD / MM / YYYY
Address []

Doctor 2. [] Phone [] Date attended DD / MM / YYYY
Address []

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

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

TREATMENT DETAILS

33. Are you receiving treatment for your illness

No Yes ▶ Provider Phone
Type
Provider Phone
Type
Provider Phone
Type

MEDICAL AND CLAIMS HISTORY

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

| | | | |
|------------------------------|---------------------------------|-------|---|
| Doctor | <input type="text" value="1."/> | Phone | <input type="text"/> |
| Address <input type="text"/> | | | |
| Treatment type | <input type="text"/> | Date | <input type="text" value="DD / MM / YYYY"/> |
| Doctor | <input type="text" value="2."/> | Phone | <input type="text"/> |
| Address <input type="text"/> | | | |
| Treatment type | <input type="text"/> | Date | <input type="text" value="DD / MM / YYYY"/> |

35. Are you entitled to or making any other insurance or compensation claim for this illness

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

| | |
|--|--|
| ▶ Bank name | |
| Account name | Account type |
| BSB | Account number |
| <i>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.</i> | |
| Signature | Date <input type="text" value="DD / MM / YYYY"/> |

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

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 | <input type="text"/> |
| Print name | <input type="text"/> |
| Date | <input type="text" value="DD / MM / YYYY"/> |

Acting as Claims Managers on behalf of
QBE Insurance (Australia) Limited ABN 78 003 191 035



PATIENT DETAILS

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

1. Name 2. Age 3. Occupation

4. Address

ILLNESS DETAILS

5. What is the diagnosis causing the patient's incapacity

6. Date the patient was diagnosed with this illness

DD / MM / YYYY

7. What caused the patient's illness

8. Is this a psychological illness

No Yes ▶ Describe the events that caused the illness and outline the clinical evidence to support the diagnosis

PLEASE ENCLOSE COPIES OF TEST RESULTS (IF ANY) WHICH HAVE DETERMINED THE ABOVE LISTED DIAGNOSIS

9. Please list any other illness(es) affecting the patient's incapacity

10. Date the patient first consulted you for this illness

DD / MM / YYYY

11. Date the patient last consulted you for this illness

DD / MM / YYYY

12. Has the patient attended further consultation for this illness or any related illness(es)

No Yes ▶

| | |
|--|--|
| 1. DD / MM / YYYY | 4. DD / MM / YYYY |
| 2. DD / MM / YYYY | 5. DD / MM / YYYY |
| 3. DD / MM / YYYY | 6. DD / MM / YYYY |

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

No Yes ▶ Provide details

15. How long have you known the patient in a professional capacity

YY / MM

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 incapacity

TREATMENT DETAILS

17. Has the patient been hospitalised

Form for question 17 with fields for dates and hospital name/phone.

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

Large text area for providing treatment details.

19. Have you provided any medical information to any other insurer regarding this illness

Form for question 19 with insurer field.

PLEASE PROVIDE MEDICAL REPORTS - IF ANY

20. Is the patient following your prescribed treatment?

Form for question 20 with details field.

21. Frequency of visits

Form for question 21 with frequency options and input field.

22. Has treatment been terminated

Form for question 22 with date ceased field.

23. Is the patient still employed

Form for question 23 with termination date field.

CAPACITY FOR WORK

24. Are there any complications that may delay the recovery

Form for question 24 with details field.

25. What is your prognosis for recovery

Large text area for providing prognosis.

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

Form for question 26 with timeframe options and input field.

27. Have you told the patient to restrict employment activities

Form for question 27 with commencement and cessation dates.

Explain the specific restrictions and limitations including hours per day/week

28. Would vocational counselling and/or retraining be recommended

Form for question 28 with details field.

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

Form for question 29 with details field.

30. How long was or will the patient be

Form for question 30 with duration and dates for disability.

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 | <input type="text"/> | Medical qualifications | <input type="text"/> |
| Signature | <input type="text"/> | Date | <input type="text" value="DD / MM / YYYY"/> |
| Address | <input type="text"/> | STAMP | |
| | <input type="text"/> | | |
| Phone | <input type="text"/> | | |
| Fax | <input type="text"/> | | |
| Email | <input type="text"/> | | |

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 illness, 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 illness
 No Yes ▶

| | |
|--|--------------|
| Has a claim been made <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ | Insurer |
| | Contact name |
| | Phone |

15. Was the worker employed at the time of suffering the illness
 No Yes ▶

| | |
|---------|----------|
| Address | Worksite |
|---------|----------|

16. When did the employee work for you

Commencement date Last day worked prior to the illness

17. Has the employee returned to work
 No Yes ▶

Date returned

18. Has the employee been made redundant
 No Yes ▶

Date

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 The last date the employee was paid sick leave

21. How many sick leave days are owing

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

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

Total Claims Solutions Pty Ltd ABN 42 389 515 023
Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited
Level 1, 151 Rathdowne Street, Carlton, Victoria 3053
T: (03) 9320 8588
F: (03) 9663 4020

www.totalclaims.com.au

