Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

PORTABLE SICK LEAVE CLAIM FORM

OFFICE USE ONLY	Claim number	Reference

COMPLETE THIS FORM IF

You are a permanent worker who has suffered an accident or illness, outside working hours and have exhausted all available sick leave entitlements with your current contributing employer.

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 and Part 1 if suffering an injury
OR
Part 2 if suffering an illness.

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

Section B

The worker's **EMPLOYER** must complete Section B (page 4) of this form.

IMPORTANT

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

CHECKLIST

- ☐ Payslip
- ☐ Medical certificate(s)
- ☐ Medical report(s) – *if any*
- ☐ Job description

Casual and Sub-Contractors are **NOT** eligible to claim Portable Sick Leave entitlements.

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 ▶ Date of termination DD / MM / YYYY

PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP

PART 1 – INJURY ONLY

20. Date of accident DD / MM / YYYY

21. Exact time of accident HH : MM am / pm

22. Date ceased work as a result of injury DD / MM / YYYY

23. Describe your injury

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

25. Where did the accident occur

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

26. Did your accident occur at work

☐ No ☐ Yes ▶ Have you submitted a claim to Workcover ☐ No ☐ Yes ▶ Insurer

Claim number

Case manager

Phone

27. How many Portable Sick Leave days are you claiming

DD

PLEASE ATTACH MEDICAL CERTIFICATE(S) & ANY MEDICAL REPORT(S)

OR

PART 2 – ILLNESS ONLY

28. Date illness commenced DD / MM / YYYY

29. Date ceased work as a result of illness DD / MM / YYYY

30. Detail the medical condition(s) you are suffering from

31. Is your illness related to your employment

☐ No ☐ Yes ▶ Have you submitted a claim to Workcover ☐ No ☐ Yes ▶ Insurer

Claim number

Case manager

Phone

32. How many Portable Sick Leave days are you claiming

DD

PLEASE ATTACH MEDICAL CERTIFICATE(S) & ANY MEDICAL REPORT(S)

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

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 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 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

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

Print name

Date DD / MM / YYYY

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

Section B — 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

9. Employment status

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

10. At the time of the injury/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. When did the employee work for you

Commencement date DD / MM / YYYY Last day worked prior to the injury/illness DD / MM / YYYY

12. Is the patient still employed with the company

☐ Yes ☐ No ▶ Termination / redundancy date DD / MM / YYYY

13. Has the employee received any payments in respect of this injury/illness for the following

☐ Sick leave ▶ Number of days Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ Annual leave ▶ Number of days Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ RDOs ▶ Number of days Provide dates

14. How many days does the employee have owing

Sick leave RDOs

15. Has the employee returned to work

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

16. What proof was provided by the employee for the sick days taken

PLEASE ATTACH MEDICAL CERTIFICATE(S), ANY MEDICAL REPORT(S) & JOB DESCRIPTION

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.

I declare this employee has used all their sick leave entitlements under the Award and needs to claim the balance of their sick days taken from the Incolink Portable Sick Leave Program.

Name

Position

Phone

Signature

Date DD / MM / YYYY

Total Claims Solutions Pty Ltd ABN 42 389 515 023
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Total Claims Solutions

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