

# 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.

**FORWARD THIS CLAIM FORM TO**

**Total Claims Solutions**  
Level 1, 62 Astor Terrace  
Spring Hill QLD 4000

**FOR CLAIM ENQUIRIES CALL**

**Total Claims Solutions**  
(07) 3230 9300

**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**

- 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. CIPL member number

2. Are you a union member  
 No  Yes

3. BUSSQ number

4. Given name(s)  Surname

5. Date of birth

6. Address (no PO Box)

7. Home phone

8. Mobile

9. Email

10. Height  cm

11. Weight  kg

12. Marital status  Married  Defacto  Single

13. Sex  Male  Female

14. Occupation

15. Do you require an interpreter  
 No  Yes

**WORKER'S EMPLOYMENT DETAILS**

16. Name of company

17. Phone

18. Date commenced

19. Employment status  
 Full-time  Part-time  Casual  Working Director  Sub-Contractor

20. Are you still employed  
 Yes  No   No  Yes

**PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP**

**ILLNESS DETAILS**

21. Date illness commenced

22. Date ceased work as a result of illness

23. Have you returned to work  
 Yes    No

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

Two empty text boxes for describing the illness(es).

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

Two empty text boxes for describing symptoms.

26. 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 border area for explaining why the illness is work-related.

27. Have you submitted a claim to Workcover

No  Yes  Insurer

Form fields for Insurer, Case Manager, Claim number, and Phone.

28. Have you had a similar condition before

No  Yes  Doctor

Form fields for Doctor, Address, Date attended (DD / MM / YYYY), and Phone.

PHYSICIAN DETAILS

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

Form fields for Doctor, Address, Phone, and Date attended (DD / MM / YYYY).

30. Details of other attending physicians

Form fields for two other attending physicians, including Doctor, Address, Phone, and Date attended (DD / MM / YYYY).

31. Who is your usual family doctor

Form fields for Doctor, Address, Phone, and How long have you been a patient at this practice (YY / MM).

TREATMENT DETAILS

32. Are you receiving treatment for your illness

Form fields for receiving treatment, including Provider, Type, and Phone for multiple instances.

MEDICAL AND CLAIMS HISTORY

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

Form fields for medical or surgical treatment history, including Doctor, Address, Treatment type, Date, and Phone for multiple instances.

34. 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.

PAYMENT DETAILS

45. 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 (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

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 any 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, Workers' Compensation Regulatory Services and or Office of Industrial Relations and or their representatives, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

I agree for the administrators of my BUSSQ, BERT and CIPL to supply details of ALL employer payments and any other payments or entitlements I may receive.

I authorise QBE Insurance (Australia) Limited or its representative to give my employer information to the CIPL Board of Trustees, if requested.

I authorise QBE Insurance (Australia) Limited or its representative to refer my claim to Mates in Construction, 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
QBE logo

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 11. Date the patient last consulted you for this illness DD / MM / YYYY DD / MM / YYYY

12. Has the patient attended further consultation for this illness or any related illness(es)
No Yes 1. DD / MM / YYYY 2. DD / MM / YYYY 3. DD / MM / YYYY 4. DD / MM / YYYY 5. 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

No  Yes ▶ From DD / MM / YYYY To DD / MM / YYYY Date treatment prescribed DD / MM / YYYY  
Name of hospital Phone

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


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

No  Yes ▶ Insurer

### PLEASE PROVIDE MEDICAL REPORTS - IF ANY

20. Is the patient following your prescribed treatment?

Yes  No ▶ Provide details

21. Frequency of visits

Weekly  Fortnightly  Monthly  Other

22. Has treatment been terminated

No  Yes ▶ Date ceased DD / MM / YYYY

23. Is the patient still employed

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

## CAPACITY FOR WORK

24. Are there any complications that may delay the recovery

No  Yes ▶ Provide details

25. What is your prognosis for recovery

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

> 1 month  1-3 Months  4-6 months  Other

27. 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

28. Would vocational counselling and/or retraining be recommended

No  Yes ▶ Provide details

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

No  Yes ▶ Provide details

30. 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

### 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"/>	<b>STAMP</b>	
	<input type="text"/>		
Phone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		

**EMPLOYER DETAILS**

1. Business/trading name 2. CIPL 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  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
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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

Number of days

The last date the employee was paid sick leave DD / MM / YYYY

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  
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