

WORKPLACE CAPITAL BENEFITS CLAIM FORM

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

You have suffered a workplace accident and wish to claim a capital benefit under the "Workplace Personal Accident Insurance Program"

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.

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

- Medical report(s) – *if any*
- Job description
- Workcover claim form and Notice of impairment benefit – *copy*
- 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

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

Date of birth

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

PLEASE ATTACH A COPY OF YOUR LAST PAYSリップ**ACCIDENT DETAILS**

21. Date of accident

22. Date ceased work as a result of accident

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

WORKCOVER DETAILS

24. Workcover insurer

Name Claim number

25. Workcover case manager

Name Phone Fax Email

26. Have you received an impairment benefit from Workcover

 No
 Yes
 Please attach the Notice of Impairment Benefit from Workcover

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

 No
 Yes
 Location 1 Amount

 Location 2 Amount
PHYSICIAN DETAILS28. Details of the **first** physician, hospital or specialist attending to your injuryDoctor Phone Date attended Address 29. Details of **other** attending physiciansDoctor Phone Date attended Address Doctor Phone Date attended Address 30. Who is your **usual** family doctorDoctor Phone How long have you been a patient at this practice Address

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

31. 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>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 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



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.

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. Advise the circumstances of the accident and how it occurred

6. Did the accident result in any of the following

<input type="checkbox"/> Permanent quadriplegia	<input type="checkbox"/> Permanent total loss of sight in one/both eyes
<input type="checkbox"/> Permanent paraplegia	<input type="checkbox"/> Permanent total loss of the hearing in both ears
<input type="checkbox"/> Permanent and incurable paralysis of all limbs	<input type="checkbox"/> Permanent total loss of lens of the one eye
<input type="checkbox"/> Third degree burns which cover more than 50% of the entire body	<input type="checkbox"/> Permanent total loss of the hearing in one ear

Permanent physical severance or permanent total loss of use of the following:

<input type="checkbox"/> Both hands	<input type="checkbox"/> One foot or one leg	<input type="checkbox"/> One joint of one finger
<input type="checkbox"/> Both arms	<input type="checkbox"/> Four fingers and one thumb	<input type="checkbox"/> All toes of one foot
<input type="checkbox"/> Both feet	<input type="checkbox"/> Both joints of one thumb	<input type="checkbox"/> Great toe – both joints
<input type="checkbox"/> Both legs	<input type="checkbox"/> One joint of one thumb	<input type="checkbox"/> Great toe – one joint
<input type="checkbox"/> One hand and one foot	<input type="checkbox"/> Three joints of one finger	<input type="checkbox"/> Each toe other than great
<input type="checkbox"/> One hand or one arm	<input type="checkbox"/> Two joints of one finger	

Other conditions:

Fractured leg or patella with established non-union

Third degree burn which covers between 20% and 49% of the entire body

Loss of at least 50% of all sound and natural teeth including capped or crown teeth – per tooth

PLEASE ENCLOSE COPIES OF TEST RESULTS & SCANS

7. Date of injury 8. Date the patient first consulted you for this injury 9. Date the patient last consulted you for this injury

10. Did the patient sustain the injury at work

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

TREATMENT DETAILS

13. Has the patient been hospitalised

No Yes From To Date treatment prescribed

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 Claim number

PLEASE PROVIDE MEDICAL REPORT(S) – IF ANY

CAPACITY FOR WORK

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

No Yes

Provide details

17. 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	<input type="text"/>	Medical qualifications	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text" value="DD / MM / YYYY"/>
Address	<input type="text"/>	<p style="text-align: center; margin-top: 0;">STAMP</p>	
	<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. Who is your Workcover insurer

11. 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

12. Was the worker employed at the time of the accident
 No Yes ▶

Address	Worksite
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13. When did the employee work for you
 Commencement date Last day worked prior to the accident

14. Has the employee returned to work
 No Yes ▶ Date returned

15. Has the employee been terminated
 No Yes ▶ Date

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