Total Claims SOLUTIONS

Incolink Entitlements 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.

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 1–2) 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 (page 3) only if Section A is complete.
The worker will be responsible for any fee charged to complete this statement.
Note, Section B is not required if claiming Carer's Leave.
A medical certificate is only required

Section C

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

IMPORTANT

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

CHECKLIST

- ☐ Current payslip
- ☐ Medical certificate(s)
- ☐ Medical report(s) – *if any*
- ☐ Job description
- ☐ Tax File Number Declaration
- ☐ Proof of identity
- ☐ Proof of bank details

Casual, Sub-Contractors and Working Directors 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

CLAIM DETAILS

15. Date your injury/illness commenced DD / MM / YYYY

16. Date you ceased work as a result of your injury/illness DD / MM / YYYY

17. Have you returned to work ☐ No ☐ Yes ▶ Date returned to work DD / MM / YYYY

18. Are you claiming for an injury or an illness or carer's leave ☐ Injury ☐ Illness ☐ Carer's Leave (provide medical certificate)

19. How many Portable Sick Leave days are you claiming DD

20. Describe your injury/illness or reason for carer's leave (note, writing the words 'medical condition' is not sufficient)

PLEASE NOTE: IF CLAIMING CARER'S LEAVE SECTION B OF THE ATTENDING PHYSICIANS STATEMENT DOES NOT NEED TO BE COMPLETED

21. If you suffered an injury please advise how the accident occurred including what you were doing prior to the accident

22. Where did the accident occur

23. Is your injury/illness work related

☐ Yes ☐ No

24. Have you lodged a claim with Workcover

☐ No ☐ Yes ▶

Insurer	Claim number
Case manager	Phone

25. Family doctor details, please provide your usual family doctor's name

NAME	PHONE

PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP, MEDICAL CERTIFICATE(S) & ANY MEDICAL REPORT(S)

PAYMENT DETAILS

26. 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

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.

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

Section B PHYSICIAN/TREATING DOCTOR

PATIENT DETAILS

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

1. Patient's name

2. Date of birth DD / MM / YYYY

3. Occupation

4. Address

State

Postcode

CONDITION DETAILS

5. Primary condition causing patient current disablement

6. Date of diagnosis DD / MM / YYYY

7. Clinical findings supporting diagnosis

8. Please confirm cause of the patient's condition (if as a result of an injury, please advise the circumstances of the patient's accident and where it occurred)

9. Has the patient's work activities caused or significantly contributed to, aggravated, accelerated, exacerbated or deteriorated the condition causing the patient's current disablement

☐ No ☐ Yes ▶ Provide details

CERTIFICATION

10. Select certification status

☐ Has no capacity for pre-injury employment from ▶ Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ Has a capacity for suitable employment from ▶ Date from DD / MM / YYYY Date to DD / MM / YYYY

☐ Has a capacity for pre-injury employment from ▶ Date from DD / MM / YYYY

11. Estimated timeframe to return to work

DAYS OR WEEKS

TREATMENT

12. What is the current and future treatment plan for the patient's condition

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

Signature

Date DD / MM / YYYY

Phone

Address

Phone

Email

Medical qualifications

Provider number

STAMP

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

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 employee 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 Email

Signature

Date DD / MM / YYYY