Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

EMERGENCY TRANSPORT CLAIM FORM

Emergency Ambulance Cover is provided via Incolink's Discretionary Fund and is governed by the Discretionary Guidelines

OFFICE USE ONLY | Claim number | Reference

COMPLETE THIS FORM IF

An ambulance has been used within Australia. Incolink guidelines will be followed when assessing this claim.

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

Claim Form

The **WORKER** must complete ALL questions on **pages 1 and 2** of the form once the Ambulance invoice has been received.

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

IMPORTANT

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

CHECKLIST

- ☐ Proof of dependant(s)
- ☐ Original ambulance invoice

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

CLAIMANT DETAILS

15. Person claiming

☐ Worker ☐ Spouse/Defacto/Child ▶

- ☐ **Defacto** – Attach a copy of at least one bill confirming the same residence.
- ☐ **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.

Dependants means;

The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months), 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.

16. Name of person claiming (if not worker)

17. Date of birth DD / MM / YYYY

PLEASE ATTACH DOCUMENTATION

WORKER'S EMPLOYMENT DETAILS

18. Name of company

19. Phone

20. Date commenced

DD / MM / YYYY

21. Employment status

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

22. Are you still employed

☐ Yes ☐ No ▶ Date of termination DD / MM / YYYY

OTHER BENEFIT DETAILS

The Incolink Emergency Transport Program requires all ambulance claims to be lodged via the relevant Australian ambulance service or your private health insurer in the first instance.

23. Are you a Pension or Health Care card holder

☐ No ☐ Yes ▶ Card number

24. Do you have private health insurance

☐ No ☐ Yes ▶ Is Ambulance cover included ☐ No ☐ Yes ▶ You must submit the claim to the appropriate health fund

AMBULANCE DETAILS

25. Date ambulance required

DD / MM / YYYY

26. Exact time ambulance required

HH : MM am / pm

27. Detail why an ambulance was required

PLEASE ATTACH ORIGINAL AMBULANCE INVOICE

28. Was the ambulance required as a result of a motor vehicle accident

☐ No ☐ Yes ▶ **You must submit the claim to the appropriate statutory scheme**

29. Was the ambulance required as a result of a work accident

☐ No ☐ Yes ▶ **You must submit the claim to the appropriate statutory scheme**

PAYMENT DETAILS

30. If this claim is accepted, how would you like to receive payment(s)

☐ Pay funds directly to Ambulance service ☐ Forward a cheque payable to myself

DECLARATION AND AUTHORISATION

I hereby authorise any Australian Ambulance Service or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim.

I authorise Total Claims Solutions to give or obtain information relating to my claim from any insurer and/or private health fund, statutory authorities, or their representatives.

I authorise Total Claims Solutions to give or obtain information to my employer.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I understand that supplying false or misleading information will result in my right to compensation being forfeited.

I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

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.

Signature

Print name

Date DD / MM / YYYY

Total Claims Solutions manage all Discretionary Cover claims on behalf of Incolink

Incolink
Redundancy Insurance Wellbeing

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

www.totalclaims.com.au

Total Claims Solutions

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