Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

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, under the ''Outside Working Hours – Illness' insurance program.

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.

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

- ☐ Proof of dependant(s) – *if any*
- ☐ 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. 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

DEPENDANTS DETAILS

15. Do you have dependants

☐ No ☐ Yes ▶ Given name(s) | Surname

Date of birth DD / MM / YYYY

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 DD / MM / YYYY

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 DD / MM / YYYY

PLEASE ATTACH A COPY OF YOUR LAST PAYSLIP

ILLNESS DETAILS

21. Date illness commenced DD / MM / YYYY

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

23. Have you returned to work

☐ Yes ▶ Date returned to work DD / MM / YYYY ☐ No ▶ Expected return date DD / MM / YYYY

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

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

26. Was an ambulance called

☐ Yes ☐ No

27. 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

28. Have you submitted a claim to Workcover

☐ No ☐ Yes ▶ Insurer | Claim number

Case Manager | Phone

29. Have you had a similar condition before

☐ No ☐ Yes ▶ Doctor | Phone

Address | Date attended DD / MM / YYYY

PHYSICIAN DETAILS

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

Doctor | Phone | Date attended DD / MM / YYYY

Address

31. Details of **other** attending physicians

Doctor 1. | Phone | Date attended DD / MM / YYYY

Address

Doctor 2. | Phone | Date attended DD / MM / YYYY

Address

32. Who is your **usual** family doctor

Doctor | Phone | How long have you been a patient at this practice YY / MM

Address

TREATMENT DETAILS

33. Are you receiving treatment for your illness

☐ No ☐ Yes ▶ Provider | Phone

Type

Provider | Phone

Type

Provider | Phone

Type

MEDICAL AND CLAIMS HISTORY

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

Doctor 1. | Phone

Address

Treatment type | Date DD / MM / YYYY

Doctor 2. | Phone

Address

Treatment type | Date DD / MM / YYYY

35. 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. 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

41. 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

We depend on the accuracy of the details you provide. Please write clearly and contact your bank if you are unsure of these details.

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 — Physician/Treating Doctor

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

DD / MM / YYYY

11. Date the patient last consulted you for this illness

DD / MM / YYYY

12. Has the patient attended further consultation for this illness or any related illness(es)

☐ No ☐ Yes ▶

1.	DD / MM / YYYY	4.	DD / MM / YYYY
2.	DD / MM / YYYY	5.	DD / MM / YYYY
3.	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		Medical qualifications	
Signature		Date	DD / MM / YYYY
Address			STAMP
Phone			
Fax			
Email			

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

ATTACH EMPLOYEE'S JOB DESCRIPTION

9. Employment status

☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ 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 ☐ No ☐ Yes ▶ Insurer
Contact name
Phone

15. Was the worker employed at the time of suffering the illness

☐ No ☐ Yes ▶ Address | Worksite

16. When did the employee work for you

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

17. Has the employee returned to work

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

18. Has the employee been made redundant

☐ No ☐ Yes ▶ Date DD / MM / YYYY

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

DD

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	DD / MM / YYYY		

Total Claims Solutions Pty Ltd ABN 42 389 515 023
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