Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

TAC TOP-UP CLAIM FORM

OFFICE USE ONLY | Claim number | Reference

COMPLETE THIS FORM IF

You have suffered an injury whilst travelling to and from work in a registered motor vehicle where cover is available through a statutory transport accident scheme and wish to claim top-up benefits.

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 1–4) 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 5–6) 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

- ☐ Direct deposit notice(s)
- ☐ TAC claim form – *copy*
- ☐ TAC acceptance letter & calculation of benefits
- ☐ Medical report(s)
- ☐ Job description
- ☐ 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

WORKER'S EMPLOYMENT DETAILS

15. Name of company
16. Phone
17. Date commenced DD / MM / YYYY
18. Employment status ☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ Working Director ☐ Sub-Contractor
19. Are you still employed ☐ Yes ☐ No ▶ Have you been made redundant ☐ No ☐ Yes ▶ Date of termination DD / MM / YYYY

ACCIDENT DETAILS

20. Date of accident DD / MM / YYYY
21. Exact time of accident HH : MM am / pm
22. Date ceased work as a result of accident 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. Describe the accident, how it happened, and what you were doing prior

25. What is the nature of your injury

ATTACH A COPY OF THE TAC CLAIM FORM, TAC ACCEPTANCE LETTER, CALCULATION OF BENEFITS & DIRECT DEPOSIT NOTICES

26. Address where accident occurred

27. Were you travelling to or from work at the time of your accident

☐ No ☐ Yes ▶ Travelled from address

Description (shop/work site)

Travelled to address

Description (shop/work site)

28. Did the police attend the accident

☐ No ☐ Yes ▶ Police officer's name Station

29. Name of witness(es) Phone

1.

2.

30. Have you lodged a claim through the Transport Accident Scheme

☐ No ☐ Yes ▶ Name of Case Manager Claim number

Phone Fax

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

☐ No ☐ Yes ▶ Location 1 Amount

Location 2 Amount

32. Have you had a similar condition before

☐ No ☐ Yes ▶ Doctor Phone

Address Date attended DD / MM / YYYY

PHYSICIAN DETAILS

33. Details of the **first** physician, hospital or specialist attending to your injury

Doctor Phone Date attended DD / MM / YYYY

Address

34. Details of **other** attending physicians

Doctor 1. Phone Date attended DD / MM / YYYY

Address

Doctor 2. Phone Date attended DD / MM / YYYY

Address

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

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

Address

TREATMENT DETAILS

36. Are you receiving treatment for your injury

☐ No ☐ Yes ▶

Commenced DD / MM / YYYY Next treatment DD / MM / YYYY Ceased DD / MM / YYYY
Provider Phone
Type

Commenced DD / MM / YYYY Next treatment DD / MM / YYYY Ceased DD / MM / YYYY
Provider Phone
Type

Commenced DD / MM / YYYY Next treatment DD / MM / YYYY Ceased DD / MM / YYYY
Provider Phone
Type

MEDICAL AND CLAIMS HISTORY

37. 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

38. Are you entitled to or making any other insurance or compensation claim for this accident

☐ Sick Leave ☐ Workcover ☐ 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

39. 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.

PLEASE SIGN DECLARATION – OVER PAGE

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

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. What is the diagnosis causing the patient's incapacity

PLEASE ENCLOSE COPIES OF TEST RESULTS, IF ANY, WHICH HAVE DETERMINED THE ABOVE LISTED DIAGNOSIS

6. Date of injury DD / MM / YYYY

7. Date the patient first consulted you for this injury DD / MM / YYYY

8. Date the patient last consulted you for this injury DD / MM / YYYY

9. Advise the circumstances of the patient's accident and where it occurred

10. What caused the patient's injury

11. Are there any conditions impacting the patient's incapacity

☐ No ☐ Yes ▶ Provide details

12. Did the patient sustain the injury travelling to or from work

☐ No ☐ Yes ▶ Provide details

13. Did the use of alcohol and/or drugs cause or significantly contribute to the patient's accident

☐ No ☐ Yes ▶ Provide details and include BAC reading if taken

14. How long have you known the patient in a professional capacity

YY / MM

TREATMENT DETAILS

15. 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

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

17. Have you provided any medical information to any other insurer regarding this injury

☐ No ☐ Yes ▶ Insurer

PLEASE PROVIDE MEDICAL REPORT(S) – IF ANY

18. Is the patient following your prescribed treatment

☐ Yes ☐ No ▶ Provide details

19. Frequency of visits

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other

20. Has treatment been terminated

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

21. Is the patient still employed

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

CAPACITY FOR WORK

22. Are there any complications that may delay the recovery

☐ No ☐ Yes ▶ Provide details

23. What is your prognosis for recovery

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

☐ > 1 month ☐ 1–3 Months ☐ 4–6 months ☐ Other

25. 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

26. Would vocational counselling and/or retraining be recommended

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

28. 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

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

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 accident, what were the gross weekly earnings (base rate of pay) excluding overtime and allowances

Base hourly rate $ Standard hours worked per week hours

11. Who is your Workcover insurer

12. 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

13. Was the employee travelling to or from work at the time of the accident

☐ No ☐ Yes ▶ Address Worksite

When did the accident occur

☐ Prior to the employee arriving and commencing that days work ▶ Scheduled Start Time HH : MM am / pm

☐ After the employee finished work that day ▶ Finish Time HH : MM am / pm

14. Was the injury reported

☐ No ☐ Yes ▶ Provide incident details

15. If the employee was partially disabled (fit for light duties), would any sedentary (light/manual work or administration) work be available

☐ No ☐ Yes ▶ Provide details

16. Was the worker employed at the time of suffering the accident

☐ No ☐ Yes ▶ Address Worksite

What date did the employee commence working for you DD / MM / YYYY

The date the employee last worked for you, prior to the accident treatment 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

PLEASE ATTACH COPIES OF ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY

PLEASE SIGN DECLARATION – OVER PAGE

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
Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited
Level 1, 151 Rathdowne Street, Carlton, Victoria 3053
T: (03) 9320 8588
F: (03) 9663 4020

www.totalclaims.com.au