Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

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"

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 4–5) 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*

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

ACCIDENT DETAILS

21. Date of accident DD / MM / YYYY

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

23. Describe your injury, how it happened and 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 DETAILS

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

Doctor | Phone | Date attended DD / MM / YYYY

Address

29. Details of **other** attending physicians

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

Address

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

Address

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

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

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.

PLEASE SIGN DECLARATION – OVER PAGE

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 write clearly and contact your bank if you are unsure of these details.

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

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

ACCIDENT DETAILS

5. Advise the circumstances of the accident and how it occurred

6. Did the accident result in any of the following

- ☐ Permanent quadriplegia
- ☐ Permanent paraplegia
- ☐ Permanent and incurable paralysis of all limbs
- ☐ Third degree burns which cover more than 50% of the entire body
- ☐ Permanent total loss of sight in one/both eyes
- ☐ Permanent total loss of the hearing in both ears
- ☐ Permanent total loss of of lens of the one eye
- ☐ Permanent total loss of the hearing in one ear

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

- ☐ Both hands
- ☐ Both arms
- ☐ Both feet
- ☐ Both legs
- ☐ One hand and one foot
- ☐ One hand or one arm
- ☐ One foot or one leg
- ☐ Four fingers and one thumb
- ☐ Both joints of one thumb
- ☐ One joint of one thumb
- ☐ Three joints of one finger
- ☐ Two joints of one finger
- ☐ One joint of one finger
- ☐ All toes of one foot
- ☐ Great toe – both joints
- ☐ Great toe – one joint
- ☐ Each toe other than great

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 DD / MM / YYYY

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

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

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 YY / MM

TREATMENT DETAILS

13. 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

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

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. 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

13. When did the employee work for you

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

14. Has the employee returned to work

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

15. Has the employee been terminated

☐ No ☐ Yes ▶ Date DD / MM / YYYY

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 DD / MM / YYYY

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