

Compulsory Third Party Personal Injury Claim Notification

To claim damages for personal injuries in a motor vehicle accident, please complete this form in **BLOCK LETTERS**

To the Insurer

Address

Postcode

1. Your personal details (being the injured person or "claimant")

1.1 Mr Mr Ms Ms Other

1.2 Given Name(s)

1.3 Surname

1.4 Date of Birth

1.5 Medicare Number

/	/		
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1.6 Home Address

Postcode

1.7 Postal Address or 'as above' if the same

Postcode

1.8 Home Phone Number

1.9 Work Phone Number

()	()
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1.10 Mobile Phone Number

()	
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1.11 Have you ever been known by another name? (eg; maiden name)

No

Yes ► Give details below

1.12 Surname

1.13 Given Name(s)

2. Do you have a solicitor acting for your claim?

2.1

No

Yes ► Give details below

2.2 Name of Firm

2.3 Name of Solicitor

2.4 Date you instructed a solicitor

/	/
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2.5 Date you first identified the relevant insurer

/	/
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3. Accident/Incident Details

3.1 Date of Accident

3.2 Time of Accident

/	/			am
				pm

3.3 Place of Accident (include street, town and state)

Postcode

3.4 Do you have the registration number of the vehicle you consider at fault?

Yes ► Give details below

No If no, go to asterisk (*) on next page

3.5 Registration Number including state registered in

3.6 Year, Make and Model of Vehicle (if known)

3.7 Colour and body type (if known)

3.8 Name and address of owner (if known)

Postcode

3.9 Home Phone Number

3.10 Work Phone Number

()	()
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3.11 Name and address of driver (if same person please write 'as above')

Form with two rows for name and address, and a label 'Postcode' at the bottom right.

3.12 Home Phone Number 3.13 Work Phone Number

Form with two rows for phone numbers, each starting with '()'.

*There is an obligation on you as the claimant to provide evidence of steps taken to find out the registration number or the owner of the vehicle you consider at fault. Please list any action taken by you to find the registration number or the name of the person who drove the vehicle you consider at fault. (Please attach any proof such as newspaper advertisement or discussions with any witnesses, etc.)

3.14 Steps taken to find details of the at fault vehicle:

Form with three rows for listing steps taken to find details of the at fault vehicle.

Details of the other vehicle(s) involved in the accident:-

3.15 Registration Number including state registered in

Form for registration number including state registered in.

3.16 Year, Make and Model of Vehicle (if known)

Form for year, make and model of vehicle (if known).

3.17 Colour and body type

Form for colour and body type.

3.18 Name and address of owner (if known)

Form with two rows for name and address of owner, and a label 'Postcode' at the bottom right.

3.19 Home Phone Number 3.20 Work Phone Number

Form with two rows for phone numbers, each starting with '()'.

3.21 Name and address of driver (if known)

Form with two rows for name and address of driver, and a label 'Postcode' at the bottom right.

3.22 Home Phone Number 3.23 Work Phone Number

Form with two rows for phone numbers, each starting with '()'.

If more than two vehicles involved please provide details of other vehicles on a separate piece of paper.

3.24 Please provide a description of the accident

Form with seven rows for describing the accident.

3.25 What was your role in the motor vehicle accident?

Form with checkboxes for Driver, Passenger, Pedestrian, Cyclist, Motor cyclist, and Other – please provide details.

3.26 Please provide the registration number of the vehicle you were in, if applicable:-

Form for registration number of the vehicle you were in, if applicable.

3.27 If you were a driver/passenger, were you wearing a seatbelt?

Form with checkboxes for No and Yes.

3.28 If you were a cyclist, motorbike rider or pillion passenger, were you wearing a helmet?

Form with checkboxes for No and Yes.

3.29 Had you consumed any alcohol or drugs in the last 12 hours before the accident?

Form with checkboxes for No and Yes.

3.30 If yes, please provide details

3.31 Do you know if Police, Ambulance, Fire Brigade or any other emergency service attended the accident?

No
Yes ► Give details below

3.32 Name of Service(s) and/or officers (if known)

3.33 Do you know if there were any witnesses or if any witness statements were taken (for example by Police)?

No
Yes ► Give details below

Witness 1 (If known)

3.34 Surname

3.35 Given Names

3.36 Home Address

Postcode

3.37 Home Phone Number 3.38 Work Phone Number

() ()

Witness 2 (If known)

3.39 Surname

3.40 Given Names

3.41 Home Address

Postcode

3.42 Home Phone Number 3.43 Work Phone Number

() ()


Please attach a list with these details if there are more than two witnesses.

3.44 Did anyone or anything other than the other driver cause or contribute to the accident? For example: the condition of the road.





No
Yes ► Give details below

3.45 Diagram of Accident

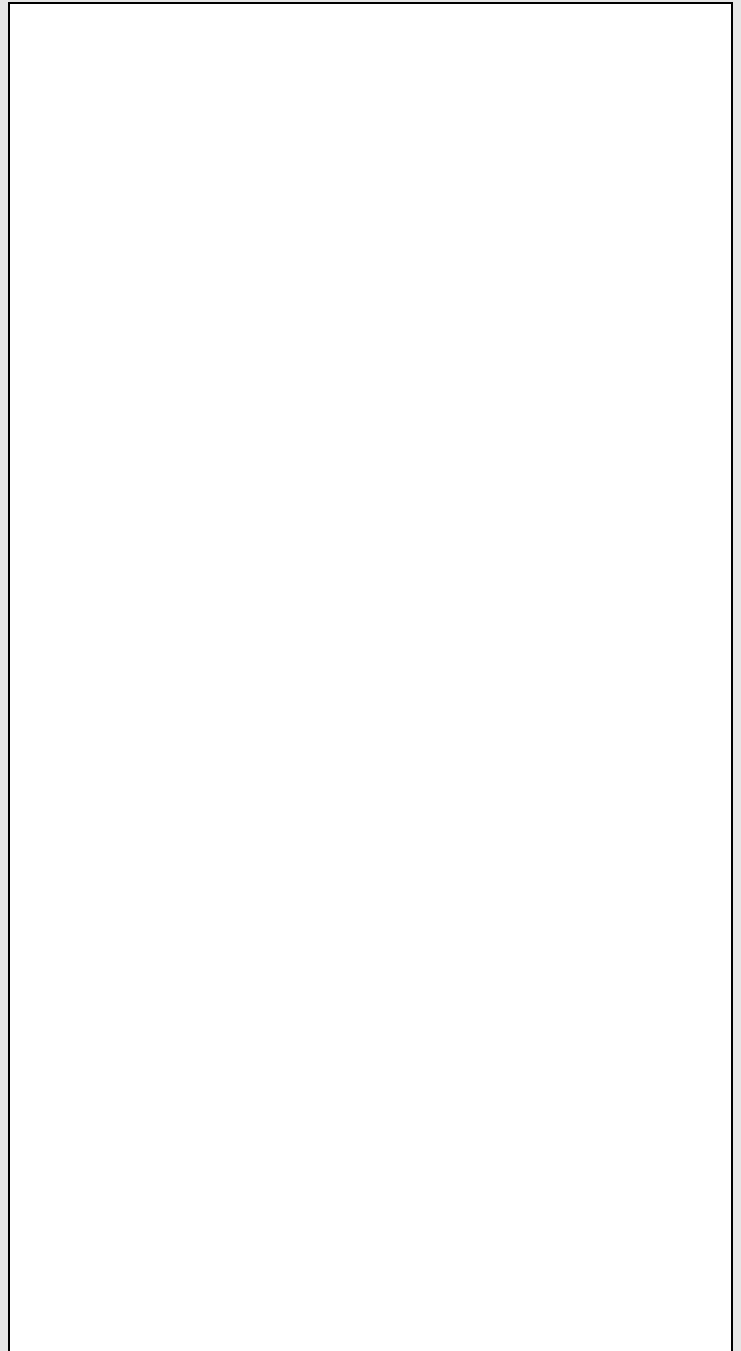
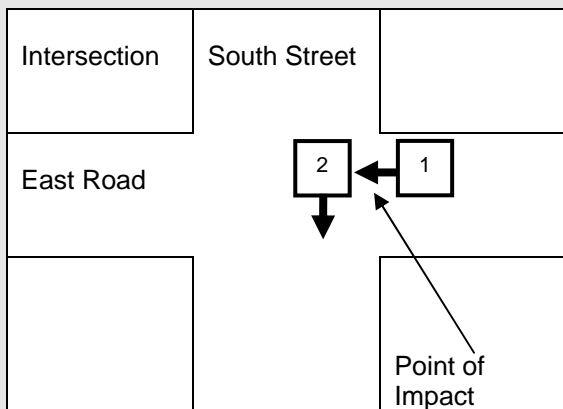
Draw a diagram of the accident. Include all intersections, streets, roads and their names. Show the point of impact and position of vehicles.

Use this box 

Symbols

-  Vehicle that caused the accident
-  Other vehicle(s)
-  Etc.
-  Pedestrian, cyclist, etc.

Example diagram



3.46 Are you receiving, or entitled to, workers' compensation as a result of this accident?

No
Yes ► Give details below

3.47 Name of Insurance Company

3.48 Policy Number (if known)

3.49 Have you lodged a claim?

No
Yes ► Give details below

3.50 Date Claim Lodged

/ /

3.51 Claim Number

4. Medical Details

4.1 What are your injuries from the accident? (List all injuries - attach a list of further injuries if you run out of space)

4.2 How do your injuries affect you now? (for example: pain in neck on bending, etc.)

4.3 Did you go to hospital after the accident?

No Go to question 4.9
Yes ► See below

4.4 Name of Hospital

4.5 Date

/ /

4.6 Were you admitted to hospital?

No
Yes ► See below

4.7 Date admitted

/ /

4.8 Date discharged

/ /

4.9 Did you see a doctor (general practitioner) after the accident?

No
Yes

4.10 If yes, doctor's name and address

Postcode

4.11 Date you first consulted the doctor

/ /

4.12 Who has medically treated or reviewed you for your injuries since the accident?

List all other doctors, surgeons, physiotherapists, specialists, etc.
(Please attach a further list if there is not enough room)

4.13 What treatment or rehabilitation are you receiving or planning to undertake?

4.14 Please provide details

Three stacked empty text boxes for providing details.

4.15 Have you previously sustained an injury to the same body parts or area that have been made worse by this accident?

No
Yes

4.16 If yes please give details

Two stacked empty text boxes for providing details.

5. Employment Details

5.1 Please advise your employment at the time of the accident.

Full time employed
 Part time employed
 Self employed
 Casual
 Retired
 Student/Child
 Home duties
 Not working
 Pension (please describe):
 Other (please describe)

5.1.1 Pension or Other description (if required)

Empty text box for pension or other description.

Please provide your employment details/job type

5.2 Occupation/Job Type

Empty text box for occupation/job type.

5.3 Name of Employer

Empty text box for name of employer.

5.4 Contact Person's Name for Employer

Empty text box for contact person's name.

5.5 Employer's Contact Phone Number

() Empty text box for contact phone number.

5.6 Workplace Address

Empty text box for workplace address.
Postcode

5.7 Please describe your work duties

Empty text box for work duties.

Usual Weekly Working Hours

5.8 Ordinary 5.9 Overtime

Two stacked empty text boxes for working hours.

Average Weekly Earnings prior to the accident (include overtime, regular bonuses and commissions)

5.10 Gross (before tax) 5.11 Net (after tax)

\$ Empty text box for gross earnings. \$ Empty text box for net earnings.

5.12 Have you lost any income as a result of this accident?

No
Yes

5.13 Have you returned to work?

5.14 Date returned to work

Yes / /

5.15 Date you expect to return to work

No / /

5.16 Is the work you do or your weekly earnings different because of the accident?

No
Yes ► Give details below

Four stacked empty text boxes for providing details.

Authorisation and Declaration

For the purpose of assessing my claim, I hereby authorise the insurer against whom this claim is made, to contact and obtain information and documents relevant to the claim for personal injury damages, sustained in the accident which occurred on/...../..... as follows:-

- 1) Clinical notes in the possession of a health service provider who treated or assessed me in relation to the personal injury.
- 2) Medical reports from health service or rehabilitation providers who have treated or assessed me for my injuries, or any pre-existing injury or condition exacerbated by the accident.
- 3) Clinical notes in the possession of any hospital (including any private hospital) where I received treatment relevant to the personal injury.
- 4) Records in the possession of an Ambulance or other emergency service that treated or assisted me in relation to the personal injury.
- 5) Clinical notes in the possession of a health service provider or hospital which treated or assessed me for the pre-existing injury or condition exacerbated by the accident.
- 6) Wage, leave and work history records in the possession of (i) my employer, (ii) anyone else who employed me at any time during the 3 years before the accident;

OR (if self-employed)
- 7) My accountant.
- 8) Any records concerning me in the possession of an insurer carrying on the business of providing CTP insurance or Workers' Compensation insurance, regarding any previous or concurrent claims.

The signing of this form constitutes my written permission to allow the insurer to obtain records or information that may affect my claim (including information on my pre-accident circumstances). Persons and entities who may be asked to provide information in relation to me are listed above.

I, the claimant (or their agent) signed hereunder, declare I understand this declaration and authorisation.

Signature of Claimant or their Agent	Date of Signing
	/ /

This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant cannot sign because they are a minor or due to injuries sustained etc, this Notice must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf of the claimant).

If the claimant is unable to sign as noted in the paragraph above, please provide details of the person who signed (agent of the claimant).

Agent's Surname		Agent's Given Name(s)

Home Phone Number		Work Phone Number		Relationship to the Claimant
()		()		

Reason(s) why the Claimant could not sign

Documents which MUST accompany this Notice of Claim

The notice of claim must be accompanied by the following documents:-

- a) the medical certificate which is attached to this form;
- b) a copy of any other document, etc. on which the claimant currently expects to rely for the claim that is in the claimant's possession.