Motor Accident Notification Form

This form is Approved Form AF2014-59, approved on 26 August 2014 by Karen Doran, delegate of the director-general, under section 276 of the *Road Transport (Third- Party Insurance) Act* 2008.
As prescribed by section 72 of the *Road Transport (Third-Party Insurance) Act 2008.*

Section 1: Your Details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr
☐ Other _____

Full Name _____

Previous Name(s) _____

Street Address _____

City _____ State _____ Postcode _____

Postal Address _____

Phone Number _____ Mobile Phone Number _____

E-Mail Address _____

Date of Birth _____ Medicare number _____

Occupation and Employer _____

Are you receiving workers compensation as a result of this accident? ☐ Yes ☐ No

If yes, Insurance Company and Claim Number (if known) _____

Section 2: Accident Details

Your role in the Accident ☐ Driver ☐ Passenger ☐ Pedestrian
☐ Cyclist ☐ Motorcyclist ☐ Pillion Passenger
☐ Other _____

Date of Accident _____ Time _____ AM/PM _____

Place of Accident (Street, Town and State) _____

Road and weather conditions _____

Describe how the accident occurred
*Please attach a diagram of the accident at the end of this form if this assists or you have been requested to do so by the insurer _____

Vehicle that caused the accident

Registration Number | State | Make

Driver Name | Phone Number

Address

Owner Name

Vehicle you were travelling in

Registration Number | State | Make

Driver Name | Phone Number

Address

Owner Name

Other vehicles involved in the accident (if known)

Registration Number | State | Make

Driver Name | Phone Number

Address

Owner Name

If you are unable to identify the vehicle at fault, please list what steps you have taken to identify vehicle

Section 3: Police Attendance/Report

Did police attend the accident? ☐ Yes ☐ No

Police accident reference number

What date was the accident reported to police?

Police station

You must report this accident to Police. If you have a copy of the Police Report please attach it to this form.

Section 4: Medical Information (To be completed by your doctor)

Claimant full name

Claimant signature

Date

Date of examination

Are the injuries consistent with the circumstances of the motor accident described to you?

☐ Yes
☐ No

Medical diagnosis or description of injury

Is treatment likely to be required

☐ Short term (6 weeks)
☐ Medium term (6-12 weeks)
☐ Long term (>12 weeks)
☐ No treatment necessary

Treatment type

☐ GP Management
☐ Allied Health Therapy
☐ Specialist
☐ Other

Detail of treatment

Doctor's information

Doctor's name

Work phone number

Area of specialty

Provider number

Address of practice

Signature of doctor

Date

Declaration

Declaration under section 72(1)(c)(i) of the Road Transport (Third-Party Insurance) Act 2008

(Please print full name in BLOCK LETTERS)

I, …… declare that I was not wholly or mainly at fault in the motor accident.

Full Name			
Date of Birth		Date of Accident	
Address			

Protection of Privacy

• The information collected by this Motor Accident Notification Form, and throughout the course of your claim, is collected in accordance with the *Road Transport (Third-Party Insurance)* Act 2008 (the Act) and Road Transport (Third-Party Insurance) Regulation 2008 (the Regulation).

• The information is collected, held, used and disclosed so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to assist the CTP regulator with the administration of the statutory insurance scheme including the detection of fraud and conducting research about the scheme. This may include the CTP regulator contacting you to discuss your claim experience.

• The information collected by this Motor Accident Notification Form and throughout the course of your claim, may be disclosed in accordance with the Act and the Regulation to such bodies as, the CTP regulator, the Nominal Defendant, and other insurers or parties involved in the assessment of your claim, such as those indicated below.

• Failure to provide all or part of the information may delay or prevent the assessment of your claim.

• You are able to gain access to personal information held as provided by the Privacy Act 1988 (Cth), or if the information is held by the Australian Capital Territory Government, you are able to gain access to the information as provided by the road transport legislation

• Any personal information you provide to the CTP Insurer will be collected, held, used and disclosed in accordance with their Privacy Policy. You will be able to view their privacy policy on their website or you can request that the Insurer send you a copy.

Authority to obtain information

For the purpose of assessing my claim, I hereby authorise the insurer against whom this notice is made, to contact and obtain information and documents relevant to the claim for the payment of early medical expenses under Chapter 3 of the *Road Transport (Third-Party Insurance)* Act 2008, for injury sustained in the accident which occurred on the date mentioned in Part B of this form 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 My accountant (if self-employed).

7. 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, or insurance against the loss of income through disability.
Records from any of the following:
- other licensed insurers;
- a department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
- a doctor, professional provider of rehabilitation services or person professionally qualified to assess cognitive, functional or vocational capacity, and
- an educational institution.

(Note: An insurer includes a reinsurer and/or overseas reinsurer)

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

Signature of claimant or their agent		Date	
Previous name		Date of Birth	
Print Name			

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 is unable to sign, this form 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). Please provide details of the person who signs as agent of the claimant below.

Agent's Full Name			
Relationship to claimant		Phone Number	
Reason(s) claimant could not sign			