NOTICE OF CLAIM FORM

This form was approved by the CTP regulator for the purposes of section 276 of the R*oad Transport (Third-Party Insurance) Act 2008* (prescribed by section 84 (Notice of Claim)).

Protection of Privacy

- The information collected by this Notice of Claim, 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 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. This may include the CTP regulator contacting you to discuss your own claim experience.
- The information collected by this Notice of Claim 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 ACT Government, as provided by the road transport legislation and the *Information Privacy Act 2014* (ACT).
- 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.

If you have already completed a Motor Accident Notification Form (MANF) and your doctor has completed the Motor Accident Medical Report (MAMR) section, please attach a copy of your signed MANF/ MAMR to this Form, and complete this Notice of Claim Form.

MANF / MAMR CTP Insurer _____ CTP Claim Number: (if known) _____

If you have not already completed the MANF/ MAMR form, please do so. Once this form is completed and signed, attach it to the completed Notice of Claim Form. The Notice of Claim Form is to be submitted to the CTP Insurer of the at-fault vehicle. Time limits apply. If you are submitting your Form after the relevant time period that applies to your claim, attach an explanation for the delay to this Form.

Part A: Your details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Dr
◯ Other _____

Full Name _____

Street Address _____

_____

City _____ State _____ Post code _____

E-Mail Address _____

Date of accident _____

For help with this form in a language other than English please call the Telephone Interpreter Service (TIS) on 131 450.

Part B: Employment Details

Employment status at the time of the accident

- ◯ Full Time Employed
- ◯ Self-Employed
- ◯ Retired
- ◯ Student/Child
- ◯ Pension
- ◯ Casual
- ◯ Part Time Employed
- ◯ Home Duties
- ◯ Not Working
- ◯ Other

If pension or other please describe:

Occupation/ Job

Employer

Name of business

Business contact person

Phone No.

Address

Description of work duties

Are you receiving workers' compensation or will there be any other type of claim (ie. public liability) as a result of this accident?

- ◯ Yes
- ◯ No

If yes, insurance company and claim number (if known)

Earnings prior to the accident

Usual Weekly Working Hours

Ordinary hours

Over time hours (if applicable)

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

Gross earnings (before tax)

Net earnings (after tax)

Lost earnings/Return to Work

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

- ◯ Yes
- ◯ No

If yes, please provide details

Have you returned to work?

- ◯ Yes
- ◯ No

Date returned to work

Date expected to return to work

Self-Employed claimants ONLY

Business Name

Principal Address

ABN

Nature of Business

Accountant's Name | Phone Number

Accountant's Address

Details of replacement labour

Part C: Legal Representation

Do you have a solicitor acting for your claim? ◯ Yes ◯ No

Name of Firm

Name of Solicitor | Reference

Date you instructed solicitor | First date relevant insurer identified

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It is an offence under section 116 of the *Road Transport (Third-Party Insurance) Act 2008* to provide false or misleading information. You can be fined up to 100 penalty units and/ or be imprisoned for up to 1 year. By signing the declaration you are declaring the information provided is true, correct and complete.

As at 1 July 2016 a penalty unit was $150 for an individual; the maximum fine would be $15,000. For up to date information on the value of a penalty unit, see section 133 of the *Legislation Act 2001*.

Declaration

I intend to proceed with a claim under section 84 of the Act.

I confirm that the information provided in this form is true and correct to the best of my knowledge.

Signature - claimant or agent | Date

Print Full name of Claimant

Signature of witness | Date

Print Full 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 the claimant). Please provide details of the person who signs as agent of the claimant below:

Agent's full name | Date of Birth

Relationship to claimant | Contact no.

Previous name (if applicable) | Reason(s) cannot sign

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 my claim under the *Road Transport (Third-Party Insurance) Act 2008*, for injury sustained in the accident which occurred on the date recorded in Part A 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 ("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 injury.
4. Records in the possession of an Ambulance or other emergency service that treated or assisted me in relation to the 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.
8. 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 the information provided is true and correct, that I understand this authorisation and that this authority is provided for by legislation and the consent provided in this authority cannot be withdrawn.

Signature - claimant or agent		Date		Date of Birth	
Print Full name of claimant					

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 the claimant). Please provide details of the person who signs as agent of the claimant below:

Agent's Full Name		Date of Birth	
Relationship to claimant		Contact no.	
Previous name (if applicable)		Reason(s) cannot sign	