



CLAIM FORM ⇌

## Journey Injury

Call ATC for assistance on (03) 9258 1777

1. **You** complete Section A.

2. Your **Medical Practitioner** completes Section B.

3. Your **Employer** completes Section C.

4. Check all questions have been answered (including by selecting either 'Yes' or 'No' wherever this option is given) and each Section has been signed and dated.

**Your claim will be delayed if we have to return your claim form to you because it is incomplete.**

5. Please keep a copy of the completed claim form and attachments for your records.

6. Send to:  
ATC Insurance Solutions Pty Ltd  
Level 2, 499 St Kilda Road,  
Melbourne VIC 3004

## SECTION A ➔ Claimant's Statement

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Sex: Male  Female  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mobile Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

What is your preferred method of communication (postal or email)? \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Project name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Employed Since: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Contact Telephone Number of Supervisor: \_\_\_\_\_

Employment Status (eg. Full-time, part-time, casual, contractor): \_\_\_\_\_

Do you work regular overtime?: Yes  No

On average how many days do you work per week: \_\_\_\_\_ Hours worked per day: \_\_\_\_\_

Please list your usual duties and percentage of time spent on each task:

DUTIES	% TIME SPENT

### Electronic Funds Transfer

If ATC approves your claim and you wish to have your claim benefits transferred directly to your bank account, please provide the following details:

Bank Name: \_\_\_\_\_ Bank Branch: \_\_\_\_\_

Account Name: \_\_\_\_\_ BSB: \_\_\_\_\_ Account No.: \_\_\_\_\_

# Injury Statement SECTION A continued

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- 1a.** Date of injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **1b.** Time of injury: \_\_\_\_ am/pm
- 2.** Did the incident happen at work? Yes  No
- 3.** On what date did you first seek medical treatment or advice? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4.** On what date were you first unable to carry out your normal duties because of your injury? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 5.** In your own words describe your injury: \_\_\_\_\_  
\_\_\_\_\_
- 6.** What part of your body was injured? \_\_\_\_\_
- 7.** Describe the incident that caused your injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8.** Where did the accident happen (provide street address)? \_\_\_\_\_  
\_\_\_\_\_
- 9.** Where were you travelling from and where were you travelling to at the time of the accident (provide the address of your departure point and intended destination)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 10.** Was your journey between your place of employment and your home? Yes  No   
If No, please advise the purpose of your journey: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 11.** Did you take your normal route? Yes  No  If No, please advise details of the route taken and why a different route was taken  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 12a.** What was your means of transport (e.g. car, bike, on foot, etc)? \_\_\_\_\_
- 12b.** If you were the driver of the motor vehicle (including a motorcycle) that was involved in the accident, was the vehicle registered and were you licensed to operate that vehicle? Yes  No
- 13.** Was an ambulance called? Yes  No
- 14.** Did the police attend? Yes  No  Police Officer's Name: \_\_\_\_\_  
Police Station: \_\_\_\_\_ Police Report Number: \_\_\_\_\_
- 15.** Do you consider that any other party is responsible for your accident? Yes  No  If Yes, provide details  
\_\_\_\_\_  
\_\_\_\_\_
- 16.** Were there any witnesses to the incident? Yes  No   
Witness name/s and contact number/s: \_\_\_\_\_  
\_\_\_\_\_

**17.** Provide details of your General Practitioner (GP) and all other medical practitioners seen for your current injury:

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			
GP:					

**18.** If we need to obtain more information about your current injury, who should we contact from the above list?

\_\_\_\_\_

**19.** Have you ever had a similar injury before? Yes  No  If Yes, please describe the injury, when and how it happened and whether there is any connection between the previous injury and the current injury and list any medical consultations below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**20a.** Have you returned to work? Yes  No  Date you returned: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**20b.** If you are unable to work, what is preventing you from doing so and what tasks are you unable to perform? \_\_\_\_\_

\_\_\_\_\_

**20c.** Are you fit for alternative duties? Yes  No  If Yes, what type of duties do you consider yourself suitable for:

\_\_\_\_\_

**21.** When do you anticipate you may be fit enough to return to full-time work? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**22.** Please give as much detail as possible about the type of treatment you are receiving \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. For this injury can you claim against any of the following (select either Yes or No)?:

- |   |                           |                          |
|---|---------------------------|--------------------------|
| a) Workers' Compensation insurance                  | Yes <input type="radio"/> | No <input type="radio"/> |
| b) Motor accident compensation insurance            | Yes <input type="radio"/> | No <input type="radio"/> |
| c) Sick leave (including portable sick leave)       | Yes <input type="radio"/> | No <input type="radio"/> |
| d) Centrelink and/or Government disability benefits | Yes <input type="radio"/> | No <input type="radio"/> |
| e) Your employer or another party                   | Yes <input type="radio"/> | No <input type="radio"/> |
| f) Superannuation fund                              | Yes <input type="radio"/> | No <input type="radio"/> |
| g) Any other insurance policy                       | Yes <input type="radio"/> | No <input type="radio"/> |

2. If you have answered Yes to any of the questions under 1, please provide further details (including the insurer's name and your claim number): \_\_\_\_\_  
\_\_\_\_\_

### Privacy Act

ATC Insurance Solutions (ATC) is bound by the requirements of the Privacy Act 1988, which sets out standards on the collection, use, disclosure and handling of personal information. ATC collects personal information from you for the purpose of providing you with insurance products, services and processing and assessing claims. Your personal information is treated with care. ATC will not release your personal information to anyone else other than the underwriters, their related entities or as permitted or required by law. If you make a claim under this insurance, ATC may disclose information to (and/or collect additional information about you from) claims investigators, claims managers, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink.

You have the right to seek access to your personal information and to correct it at any time. If you require further information or would like a copy of ATC's Privacy Policy please contact our Privacy Officer on (03) 9258 1777 or write to ATC at the address given on page 1. A copy of our Privacy Policy can also be obtained from our website.

### Medical Authority

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims or claims with any other insurer to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

### Declaration

**I declare that:**

- the claim I am making IS NOT WORK-RELATED and if my injury is work-related, I have disclosed this clearly in my answers in this Section, and**
- my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.**

Signature: \_\_\_\_\_

Name (Print): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Important notice: You have declared this claim is not work-related. If a claim is made under this policy that is rightfully a Workers' Compensation claim it is possible a fraudulent act has been committed that may result in prosecution.**

**You must tell us if you return to work or become medically fit to do so. If you fail to tell us and continue to receive benefits under the policy you could be prosecuted for fraud. You might also lose all of your rights under the policy for this claim and any future claims.**

## SECTION B Medical Practitioner's Statement

**Important: the claimant is responsible for any fee for this statement. Please provide as much detail as possible.**

Claimant's Full Name: \_\_\_\_\_

Sex: Male  Female  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

**1a.** Date of injury (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_ **1b.** Time of injury: \_\_\_\_\_ am/pm

**2.** Date you were first consulted for this condition: \_\_\_\_/\_\_\_\_/\_\_\_\_

**3.** What is your current diagnosis of the claimant's condition? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**4.** Date of onset of first symptoms of the claimant's condition: \_\_\_\_/\_\_\_\_/\_\_\_\_

**5.** Are the symptoms referred to in question 4 consistent with your current diagnosis? Yes  No

**6.** What was the proximate cause of the condition? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**7.** What is currently disabling the claimant causing absence from work? \_\_\_\_\_

\_\_\_\_\_

**8.** Is any other injury or sickness contributing to the disablement? Yes  No  If Yes, give details: \_\_\_\_\_

\_\_\_\_\_

**9.** What tests to determine a diagnosis have been undertaken and what further tests are anticipated? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**10.** Has the claimant previously been hospitalised for this condition? Yes  No

If Yes, advise details: \_\_\_\_\_

**11.** Has treatment or advice been sought from other medical practitioners? Yes  No

If Yes, advise the details of the consultations:

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			

# Medical Practitioner's Statement ➔ SECTION B continued

12. Have you ever advised the claimant that he or she could cease all treatment or advice? Yes  No
- 13a. Has the claimant ever previously suffered from the same or a related condition? Yes  No  If Yes, advise details of the previous condition and who treated the claimant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 13b. If a re-occurrence of the *same* condition was this to be expected? Yes  No
- 13c. If an occurrence of a *related* condition was this to be expected? Yes  No
14. Do you consider that the claimant has been (or will be) wholly and continuously prevented from carrying out his or her usual duties? Yes  No
15. If you answered Yes to question 14, please advise the applicable period:  
From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_
16. Is there anything in the claimant's history that may delay recovery? Yes  No  If Yes, please provide details and how long recovery may be delayed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
17. What is the claimant's treatment/rehabilitation programme? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. What is the claimant's prognosis? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
19. When will the claimant be fit for: a. Full duties: \_\_\_\_/\_\_\_\_/\_\_\_\_ b. Alternative duties: \_\_\_\_/\_\_\_\_/\_\_\_\_
20. Is the cause of the condition related to work or a motor accident? Yes  No   
If Yes, advise details: \_\_\_\_\_  
\_\_\_\_\_

**I hereby certify that I have personally examined the above-named claimant.**

Name: \_\_\_\_\_ Qualification: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

AFFIX STAMP HERE



## SECTION C ➔ Employer's Statement

In order to process this claim we require a 12 month pay report substantiating the claimant's average weekly earnings and a copy of the claimant's job description.

Company Name: \_\_\_\_\_

Project name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

1. I hereby certify that (insert claimant's name) \_\_\_\_\_ has been unable to attend to his or her usual duties as a result of injury commencing on \_\_\_\_/\_\_\_\_/\_\_\_\_
2. The claimant has been totally  / partially  disabled since \_\_\_\_/\_\_\_\_/\_\_\_\_ and is due to return  / did return  to work on \_\_\_\_/\_\_\_\_/\_\_\_\_
3. The *average* weekly income including all overtime and allowances (before personal deductions and income tax) paid to the claimant earned from personal exertion during the 12 month period immediately preceding disablement was \$ \_\_\_\_\_
4. During the period of disablement the claimant has received from the company:

	TOTAL \$	FROM	TO
NORMAL PAY		/ /	/ /
RDOs		/ /	/ /
CURRENT SICK LEAVE		/ /	/ /
CURRENT ANNUAL LEAVE		/ /	/ /
SALARY IN LIEU OF NOTICE		/ /	/ /
WORKERS' COMPENSATION		/ /	/ /
OTHER (PLEASE SPECIFY)		/ /	/ /

If 'Workers' Compensation' or 'Other' please describe (including the name of the insurance company, claim/policy number and contact details): \_\_\_\_\_

5. The claimant has been employed since \_\_\_\_/\_\_\_\_/\_\_\_\_ on a: Full Time  Part Time  Casual  Contractor  basis
6. Claimant's current status: Still an employee Yes  No   
Terminated on \_\_\_\_/\_\_\_\_/\_\_\_\_ To be terminated on \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Are you prepared to offer the claimant suitable alternative duties? Yes  No  If Yes, please provide details of those duties: \_\_\_\_\_
8. Is the claimant's injury work-related? Yes  No
9. Is the claimant entitled to lodge a workers' compensation claim for this injury? Yes  No

### Declaration

**I hereby declare that the claimant's injury IS NOT WORK-RELATED, and the above answers are true and complete.**

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Important notice: You have declared above that the claim IS NOT work-related. If a claim is made under this policy that is rightfully a Workers Compensation claim it is possible that a fraudulent act has been committed that may result in prosecution. Furthermore, by making a claim under this policy, the Claimant may forego any long-term benefits and rights under Workers Compensation.**