

SECTION TWO - ILLNESS

Give the exact date your illness commenced?													
When did you cease work as a result of this illness?													
State in full detail the illness/es you are suffering from - "Medical condition" is not sufficient													
Is your illness related to your employment?	<input type="checkbox"/> NO <input type="checkbox"/> YES		If yes, have you lodged a claim with WorkCover? If so, please										
provide: WorkCover Insurer:													
Claim number				Contact Name					Phone No.	()			
How many PSL days are you claiming?													
PLEASE SUPPLY YOUR MEDICAL CERTIFICATE & MOST CURRENT PAYSIP													

PRIVACY

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com or contact the Compliance Manager on (02) 9375 4656 or email compliance.manager@qbe.com for further information.

PAYMENT DETAILS

If your claim is accepted, please advise what method you would like to receive payment.

Cheque Electronic Fund Transfer

To enable your benefits to be paid directly into your bank account you need to fill in your bank details below. This will give you direct access to the funds instead of waiting for a cheque to be cleared.

PLEASE NOTE: We depend on the accuracy of the details you are providing to us. Please write clearly and check with your bank if you are unsure of the bank details.

Name of Bank							Bank Phone Number						
BSB Number (6 digits)							Type of Bank Account i.e. Savings						
Bank Account Number							Name in which Account is held						
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						
Print Name													

DECLARATION & 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 any 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 understand that Total Claims Solutions Pty. Ltd act as claims managers on behalf of QBE Insurance (Australia) Limited
 - I also authorise that 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 the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.
 - I also agree for the administrators of my BUSSQ, BERT and CIPQ to supply details of all employer payments and any other payments or entitlements I may receive.
 - I declare that the preceding statements and information are, to the best of my knowledge and belief, true in every aspect.
 - I understand the claim may be refused if information is not true or is withheld.
- The signatory must be authorised to sign on behalf of all named persons.

Signature							Date						
Print Name													

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM

SECTION B - THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER

Business/Trading Name			
CIPL Employer Number			
Address			
	State		Postcode
Telephone Number ()	Fax Number ()		
E-mail			

Name of Employee			
What is the Employee's Job Classification? (occupation).			
The employee's hourly base rate of pay at the time of the injury/illness	\$		
The employee works _____ hours per week (not including any overtime/RDO ie, 38)			
What date did the employee commence working for you?	____/____/____		
What date did the employee last work, as a result of his/her injury/illness?	____/____/____		
Is the employee still employed with the company?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If no, please state date of termination: ____/____/____	
Supply address of worksite where worker was stationed prior to the injury/illness.			
Has the employee returned to work? If so, please confirm date.	____/____/____		
How many paid sick leave days has the company paid prior to this claim? Also, please advise last sick day paid.	Number of Days _____ ____/____/____		
How many paid sick leave days including R.D.O's and Annual Leave have been paid against this claim. Please complete the following			
Type	Total number of days paid	Period paid	
Sick Days		From	To
R.D.O's		List days	
Annual leave		List days	
What proof was provided to you by the employee for the sick days taken?			

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.

Officer's Name (Print)	Position	
Telephone Number ()	RTW Coordinator	
Signature	Date	____/____/____

PLEASE ATTACH COPY OF CURRENT PAYS LIP