

SELF EMPLOYED PERSONAL ACCIDENT CLAIM FORM

This form is to be completed when a self employed worker has suffered an accident and wishes to claim Weekly Benefits. This form should be completed as soon as it appears that you will be off work due to an accident.

The form has two parts which need to be fully completed.

Section A INSURANCE STATEMENT

The insured needs to complete ALL questions in this section of the form, being the first 3 pages. Incomplete answers and vague information will delay the assessment of your claim.

Section B ATTENDING PHYSICIANS STATEMENT

The insured's treating doctor must complete the Attending Physicians Statement following completion by the Insured of the Insured's statement (section A). Any charge for completion of this statement must be borne by the Insured.

IMPORTANT

A claim, cannot be assessed until we receive the ORIGINAL claim form, completed in FULL, by the Insured, and Attending Physician. The issue of this form does not constitute an admission to liability on the part of Us.

Please forward the claim form to:

TOTAL CLAIMS SOLUTIONS PTY LTD
A.B.N. 42 389 515 023
(Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited A.B.N. 78 003 191 035)
Level 6, 101 Wickham Terrace, Brisbane, QLD 4000
PHONE: (07) 3839 8322 FAX: (07) 3839 8500

SECTION A INSURED DETAILS

Insured Person	Surname				Name(s)			
Business Trading Name				ABN				
Address (No PO BOX)				State		Postcode		
Telephone number	Private	()		Business	()	Mobile		
Date of birth				Height		Cm	Weight	Kg
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Defacto	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female		

EMPLOYMENT DETAILS

- What is your job specification and usual duties?

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- Please state your current Gross weekly earnings. **Please attach a copy of your most recent tax return**

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- If you were partially disabled (fit for light duties), would any sedentary (light/manual work or administration) work be available? If so, please give details.

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- Were you working before your accident? If so, please provide us with the site name and address of where you were working.

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Please attach a copy of your most recent tax return including details of your Profit and Loss Expenditure

ACCIDENT DETAILS

Give the exact date and time the accident occurred.										am/pm	
When did you cease work as a result of this injury?											
Have you returned to work,? If so, please provide date											
If you have not returned to work, please advise the date you expect to return to work.											
Describe your injury											
State in full detail exactly how the accident occurred, together with the circumstances surrounding your accident, ie what were you doing prior to the accident.											
Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other. If other please advise.											
Address where accident occurred?											
Name & Addresses of any witnesses to the accident 1.											
2.											
Had you consumed any alcohol or drugs within the 8 hours prior to the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES											
If yes, amount _____ Where _____											
Did the accident occur at work? <input type="checkbox"/> NO <input type="checkbox"/> YES If Yes, provide the following											
Address of Workplace											
Name of Client								Contact Name			
Contact details		Phone Number ()		Fax Number ()							
On this job, were you: (please tick relevant box)		a) Did you have a written contract with your client? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Were you getting paid an agreed price <input type="checkbox"/> or Paid on an hourly/daily rate <input type="checkbox"/> c) Did you provide all your own plant and equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, was it because no tools were required for the job <input type="checkbox"/> or they were supplied by the contractor <input type="checkbox"/> d) Were you legally liable for the cost of rectifying any defect in the work you were performing? <input type="checkbox"/> Yes <input type="checkbox"/> No									

YOUR PHYSICIAN'S DETAILS

Give the details of first physician/hospital or specialist attending to you for this injury.											
Doctor's Name		Address				Telephone		Date attended			
						()					
Details of all other attending physicians and dates attended.											
Doctor's name		Address				Telephone		Date attended			
						()					
						()					
Who is your usual family doctor?											
Doctor's name		Address				Telephone					
						()					
How long have you been receiving treatment or advice from this doctor?								Years		Months	

TREATMENT DETAILS

Are you receiving treatment for your injury? If yes, please give details of the treatment you are presently receiving.

Type of treatment

Date commenced

Date of next treatment

Date treatment ceased

Name and contact no. of provider

Name

Telephone

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MEDICAL & CLAIMS HISTORY

What other medical or surgical treatment have you received during the past 5 years?

Date	Nature of treatment	Doctor's Name	Address

Are you making or entitled to make any other insurance or compensation claim in respect of this disability?

Sick Leave NO YES Motor Compensation NO YES WorkCover NO YES

Private Health Fund NO YES Other Government Benefits NO YES Superannuation Life Insurance NO YES

Other _____

Name of fund/insurance company

Case Manager

Claim Number

Telephone

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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			

SECTION B - ATTENDING PHYSICIAN'S STATEMENT

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

TO BE COMPLETED BY YOUR TREATING DOCTOR / SURGEON

Patient's Name	Age	Occupation

Patient's Address

Exact nature of patient's injury. Please list in full detail all injuries the patient is disabled from.

PLEASE ENCLOSE RESULTS OF ANY TESTS PERFORMED, WHICH HAVE DETERMINED THE ABOVE DIAGNOSIS.

The date of the patient's injury	____/____/____
When did the patient first consult you for this injury?	____/____/____
When did the patient last consult you for this injury?	____/____/____

Please advise the circumstances of the patient's accident and where the accident occurred.

If the patient's injury was not as a result of an accident what is the cause of the patient's injury?

Are there any conditions impacting the patient's disablement? Please give details.

Did the patient sustain an accident at work? Please give details.

Was the patient playing in competitive sport at the time of his/her accident? If "Yes" please provide details.

Are you aware if the patient has in the past or currently participates in any sporting activities, whether it be a team or individual sport? Please provide any details.

How long have you known this person in a professional capacity?	Years	Month
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SECTION B - ATTENDING PHYSICIAN'S STATEMENT - CONTINUED

Has patient ever had the same or a similar condition? If "Yes" state when and describe whether this has an impact on current disablement

Has the patient been hospitalised? NO YES If yes, Name of Hospital

Date of Admission ____/____/____ to ____/____/____ What date was the treatment prescribed? ____/____/____

Please give full details of treatment prescribed and results of that treatment including any surgery or medication prescribed.

Has treatment been terminated? If so, please give date ceased.

Frequency of Visits Weekly Monthly Other _____

Is the patient following your prescribed treatment? NO YES If No, please give details.

When will the patient be fit to return to his/her normal occupation or alternative duties? Please state which.

Are there any complications that may delay the recovery? If Yes, provide details.

What is your prognosis?

Have you told the patient to restrict employment activities? If so, please advise the date the restrictions commenced and ended.

Commenced _____ Ended _____

Explain the specific restrictions and limitations.

Do you expect a fundamental or marked change in the patient's injury? If yes, when will the patient recover sufficiently to return to work?

1 month 1-3 months 4-6 months Other _____

Can present job be modified to allow the patient to work with their disability? If yes, please advise the date the trial will commence and indicate whether full-time or part-time. If part-time, how many hours per day/week.

Would vocational counselling and/or retraining be recommended? If yes, please specify.

With regard to the patient's occupation, how long was or will patient be continuously totally disabled? (Unable to perform any part of his/her occupation)

TOTALLY DISABLED FROM: _____ TO: _____ (BOTH DATES INCLUSIVE)

How long was or will patient be partially disabled? (Unable to perform some part of his/her occupation)

PARTIALLY DISABLED FROM: _____ TO: _____ (BOTH DATES INCLUSIVE)

Name (Please Print) _____ Date _____

Address (Please Print)

Phone Number () _____ Fax Number () _____ E-mail _____

E-mail

Medical Qualifications

Signed