

WORKCOVER TOP-UP CLAIM FORM

This form is to be completed when the worker has been in receipt of WorkCover benefits for 26 weeks and providing the worker is in receipt of weekly compensation benefits and the injury occurred within the period of insurance. This form should be completed as soon as it appears that you will exceed more than 26 weeks of WorkCover compensation payments.

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

Section A WORKERS STATEMENT

The worker 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 workers treating doctor must complete the Attending Physicians Statement following completion by the Worker of the Workers statement (section A). Any charge for completion of this statement must be borne by the worker.

Section C EMPLOYER STATEMENT

The workers employer must complete Section C of this form.

IMPORTANT

A claim, cannot be assessed until we receive the ORIGINAL claim form, completed in FULL, by the Worker, Attending Physician and Employer. 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 MEMBER DETAILS

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|-------------------------|---|-----------------------|--------------------------|-------|--------------------------|--------------|--------------------------|---------------|-------------------------------|---------------------------------|--------------------------|--------------|----|--|
| Union Membership number | | Are you (please tick) | <input type="checkbox"/> | BLF | <input type="checkbox"/> | CFMEU | <input type="checkbox"/> | CEPU | <input type="checkbox"/> | NO UNION | <input type="checkbox"/> | BUSSQ Number | | |
| Worker | Surname | | | | | | | Given name(s) | | | | | | |
| Address (No PO Box) | | | | | | | | | | | | | | |
| | | | | State | | | | Postcode | | | | | | |
| Telephone number | Private () | | | | | Business () | | | | Mobile | | | | |
| Date of birth | | | | | | Height | | Cm | Weight | | | | Kg | |
| Occupation | | | | | | | | Sex | <input type="checkbox"/> Male | <input type="checkbox"/> Female | | | | |
| Marital status | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto | | | | | | | | | | | | | |

EMPLOYMENT DETAILS (attach copy of last or most recent payslip)

| | | | | | | | | | | | | | | |
|--|--|--|--|-------|--|------------|-----|----------|--|--|--|--|--|--|
| Name of company | | | | | | | | | | | | | | |
| Payroll officer | | | | | | | | | | | | | | |
| Company address | | | | | | | | | | | | | | |
| | | | | State | | | | Postcode | | | | | | |
| Phone Number | () | | | | | Fax Number | () | | | | | | | |
| What date did you commence employment with this company? | | | | | | | | | | | | | | |
| Are you still employed? | <input type="checkbox"/> NO <input type="checkbox"/> YES | | | | | | | | | | | | | |
| If no when did you cease employment? | | | | | | | | | | | | | | |

PLEASE ATTACH ALL COPIES OF YOUR PAYSLEIPS FROM THE 26th WEEK OF WORKCOVER BENEFITS
OR
IF WORKCOVER IS PAYING YOU DIRECT, PLEASE SEND YOUR PAYMENT/REIMBURSEMENT STATEMENT
FORM THE 26th WEEK OF WORKCOVER BENEFITS

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 |
|------|---------------------|---------------|---------|
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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 () _____

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.

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|------------|--|--|--|--|------|--|--|--|--|--|--|
| 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 |
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|-------------------|--|
| Patient's Address | |
|-------------------|--|

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

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

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| The date of the patient's injury | ____/____/____ |
|----------------------------------|----------------|

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|---|----------------|
| When did the patient first consult you for this injury? | ____/____/____ |
|---|----------------|

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|--|----------------|
| When did the patient last consult you for this injury? | ____/____/____ |
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Please advise the circumstances of the patient's accident and where the accident occurred.

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

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

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

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Has the patient's work activities caused or significantly contributed, aggravated, accelerated, or exacerbated or deteriorated a pre-existing condition causing the patient's current disablement? Please give details.

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

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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.

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Give details of any circumstances such as the use of alcohol and or drugs, which may have caused or significantly contributed to the patient's accident. Please also include BAC readings, if taken.

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| How long have you known this person in a professional capacity? | Years | Month |
|---|-------|-------|

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

SECTION C - 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). | | | |
| Please state the Employees current Gross weekly earnings excluding overtime & allowances at the date of injury. (The base rate of pay). | | \$ | |
| Reason employee stopped working? | <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Other (please specify) _____ | | |
| Is the employee entitled to Workers' Compensation benefits? | <input type="checkbox"/> NO <input type="checkbox"/> YES | If yes, please confirm the details of this claim including a copy of the WorkCover Claim form | |
| Insurer | | Claim Number | |

ATTACH A COPY OF THE JOB DESCRIPTION CARRIED OUT BY THE EMPLOYEE.

If employee was 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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| RTW Coordinator's Name | | Telephone | () |
| Was the worker employed at the time of suffering the accident? | <input type="checkbox"/> NO <input type="checkbox"/> YES | If yes, provide address and worksite where worker was stationed prior to injury? | |
| Job Site | Address | | |

| | |
|---|---|
| What date did the employee commence working for you? | ___/___/___ |
| The date the employee last worked for you, prior to the accident? | ___/___/___ |
| Has the employee returned to work? | <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, what date? ___/___/___ |
| Has the employee received any sick leave payments in respect of the injury being claimed? | <input type="checkbox"/> NO <input type="checkbox"/> YES Number of days ___ |
| The last date the employee was paid sick leave. | ___/___/___ |
| How many sick leave days does the employee have owing? | Number of days entitled _____ |

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 () | E-mail | | |
| Signature | | Date | ___/___/___ |

PLEASE ATTACH COPIES OF ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS INJURY.