

Common Law Claim Form



Please answer all questions and tick boxes where appropriate. Leaving a question blank may delay the processing of this form.

Name of person completing this form

Relationship if not claimant

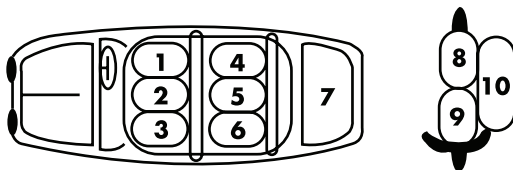
1. Injured Persons Position in Vehicle

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

a) Was the injured person a:

Driver / Rider Cyclist Passenger / Pillion Pedestrian

b) Position in Vehicle:



c) Were you (the claimant) wearing a seatbelt / helmet?

Yes No Give Details Not Applicable

d) Were you (the claimant) sitting or standing other than in a designated seat? (eg. in rear of ute, standing on a bus)

Yes Give Details No

2. Accident Description

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

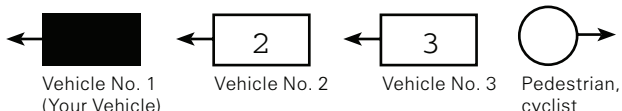
a) Date of Accident

Day of the week

Time (am/pm)

Give exact location of accident (street and suburb)

b) Using symbols shown draw accident diagrams including streets, any landmarks and directions of travel of all vehicles.



Give a description of the accident and include if mechanical failure was a contributory factor (eg. bald tyres, faulty brakes).

c) Were there any unusual circumstances in the accident (eg alcohol, drugs, false details, faulty vehicle or unusual behaviour)?

Yes Please specify No Unknown

d) Was the accident reported to the police?

Yes Give Details No

Date reported / / Police report number

Which Police station?

e) Did the police attend the accident scene?

Yes No Unknown

f) Was alcohol, drugs or medication consumed by you (the claimant) in the 12 hours prior to the accident which you are now reporting?

Yes Give Details No

How much, what quantity was consumed and when?

g) Do you (the claimant) have a certificate showing the results of your breath analysis / blood specimen?

Yes Give Details No

What alcohol level was recorded?

3. Vehicle / Driver details

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

a) Details of vehicle involved (Vehicle No. 1)

Registration number State of Registration

Make Model Year

Body type Colour

Driver's particulars (Vehicle No. 1)

Title Ms Mrs Miss Mr Other

Surname / Family name Given names

Postal address

TOWN / SUBURB

STATE

POST CODE

Phone numbers () () ()
HOME WORK FAX MOBILE

Had the driver consumed any alcohol, drugs or medication prior to the accident? Yes Give Details No Unknown

How much, what quantity was consumed and when?

b) Details of other vehicle involved (Vehicle No. 2)

Registration number State of Registration
Make Model Year
Body type Colour

Driver's particulars (Vehicle No. 2)

Title Ms Mrs Miss Mr Other
Surname / Family name Given names
Postal address
TOWN / SUBURB STATE POST CODE
Phone numbers () () ()
HOME WORK FAX MOBILE

4. Injured Persons Details (Claimant)

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

Your full details (Claimant)

Title Ms Mrs Miss Mr Other
Surname / Family name Given names
Are you known by any other name: If so, give details
Residential address
TOWN / SUBURB STATE POST CODE
Postal address
TOWN / SUBURB STATE POST CODE
Phone numbers () () ()
HOME WORK FAX MOBILE
Email address
Date of birth / / Sex M F
Occupation Self employed Yes No
Name and address of employer?
Medicare number Preferred language

5. Details of Bodily Injuries

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

a) What is the nature and extent of your (the claimant's) injury(ies)?

If more than one injury, list in order of severity and describe injury as per the following examples:

Injury to: **Head** Description: **Broken Jaw, Concussion, Cut to left cheek etc**
Injury to: **Leg** Description: **Dislocated left knee etc**
Injury to: **Foot** Description: **Broken right little toe etc**
Injury to: **Neck** Description: **Whiplash etc**
Injury to: **Chest** Description: **Seatbelt bruising to Ribs etc**

Please Complete your details below:

Injury to	Description of Injury

b) Give names and addresses of treating doctors, physiotherapists, chiropractors, etc.

Name and address

c) Did you attend a hospital?

Yes Give Details No

Name of hospital

Was this a casualty attendance only or were you admitted? Casualty only Admitted Give Details

Admission Date / / Discharge Date / /

d) Are you (the claimant) still receiving treatment?

Yes Give Details No

What kind of treatment (eg. physiotherapy, chiropractic etc)

e) Is this a claim for medical expenses only?

Yes No

6. Details of Lost Wages

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

a) Have you (the claimant) had time off work?

Yes Give Details No

b) Have you (the claimant) lost any income?

Yes Give Details No

How much Gross \$ Nett \$

What is your currently weekly wage \$

7. Details of Previous Injuries and Claims

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

a) Are you (the claimant) currently receiving Workers Compensation or any other type of benefits?

Yes Give Details No

Centrelink

Invalid / Disability

Workers Compensation

Name of Workers Compensation Insurer, exempt employer or Claims Agent and claim reference number.

b) Are you (the claimant) receiving or entitled to receive benefits under a Personal Accident, Income Protection or Travel Cover Insurance as a result of this accident?

Yes Give Details No

Name of Insurer & Claim Reference Number

c) Did you (the claimant) have any physical impairment prior to this accident? (eg. neck or back problems) Yes Give Details No

d) Give names and addresses of previous treating doctors, physiotherapists, chiropractors, etc.

Name and address

Name and address

e) Have you (the claimant) been involved in any prior accidents (eg. sports, work, home, car etc.)? Yes Give Details No

Date	Type of Injury	How it occurred (eg. sport, work, at home)
/ /		
/ /		
/ /		

f) Have you made any kind of injury claim before? Yes Give Details No

Date of injury / /

State nature of injury

Give names and addresses of previous treating doctors, physiotherapists, chiropractors, etc.

Name and address

Name and address

9. Authorities

(PLEASE PRINT NEATLY USING CAPITAL LETTERS)

- 1 To obtain blood specimen result / police report / breath analysis certificate from Police Department or Forensic Science Centre.
- 2 Medical Information.
- 3 Any other information relating to my claim including from an employer or previous employer, Ambulance Service, other Insurers or other Government Departments, State or Commonwealth.

Name

Address

TOWN / SUBURB

STATE

POST CODE

Date of birth

authorise TIO to obtain a copy of the blood specimen result from the Forensic Science Centre which I had taken from me at

Name of Hospital Date

and / or a copy of the breath analysis certificate from the Police Department and / or a copy of the Police Report including all statements, plans, photos, Police mechanical reports and like material relating to the subject accident.

I authorise my treating doctor(s) to supply TIO with full details regarding my medical condition, treatment rendered, and allow the examination of any records, x-rays, held by my treating doctor(s).

I authorise TIO to contact any of the above mentioned to obtain information and documents relative to my claim.

I direct that any of the above mentioned information be provided upon the provision of a clear photocopy or imagery reproduction of this authority.

Signature Date

Witness of Claimant Signature *(any person over 18 years old)*

Signature Date

10. Authority for Release of Information from Centrelink (PLEASE PRINT NEATLY USING CAPITAL LETTERS)

This authorisation includes the release of information from Centrelink that may relate to my claim for compensation under the *Motor Accidents (Compensation) Act*.

I, request access to a copy of the following documents, and information, from Centrelink Records:

- All my medical documents and information
- Details of earnings from employment declared to centrelink for the period
- Type and amount of Centrelink payments for the period
- Other or past Compensation claim details on my Centrelink records

I authorise Centrelink to forward copies of these documents and information to TIO Motor Accidents Compensation Department

My personal particulars are:

Name DOB

Centrelink Customer Reference Number

Applicant

Witness