TIAIB Personal Accident/ Taxi Association Claim Form

THIS FORM SHOULD BE COMPLETED AND FORWARDED TO:	
Echelon Claims Services A division of Echelon Australia Pty Ltd ABN 96 085 720 056 GPO Box 1693 ADELAIDE SA 5001	Facsimile: 08 8235 6450 Toll Free: 1800 640 009 Email: ecssa@echelonaustralia.com.au www.Marsh.com.au

PERSONAL ACCIDENT / TAXI ASSOCIATION CLAIM FORM
IMPORTANT We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you: 1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim. 2. Provide a comprehensive description of the circumstances of the accident / injury or the sickness. 3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.

PERSONAL STATEMENT					
Claimant Name:					
Postal Address:					
				Postcode:	
Telephone No.:				Mobile No.:	
Email Address:				Facsimile No.:	
Date of Birth:		Height:		Weight:	
Occupation / Duties:					
Taxi Owners Name:				Telephone No:	
Cab Number:			Registration Plate Number:		
Length of Employment / Contracting:					

FOLLOWING CLAIM ACCEPTANCE BY YOUR INSURER, PLEASE ADVISE PREFERRED METHOD OF PAYMENT				
EMPLOYER PLEASE CONFIRM: Please make Payment Payable to :			YES ☐	NO ☐
Cheque ☐	Direct Payment ☐	If you selected Cheque, nominate payee		
If you have selected Direct Payment please supply the following information (alternatively supply a deposit slip noting the following information)				
Bank:		Account Name:		
Branch No.:		Account Number:		

CLAIMANT DECLARATIONS & MEDICAL AUTHORISATIONS			
I _____solemnly and sincerely DECLARE that the information given by me in this claim is true and complete. I UNDERSTAND and agree that if I make any false or fraudulent statements or fail to inform Echelon Claims Services/Underwriter of any relevant information regarding my claim that my claim may be declined. I UNDERSTAND that I can be prosecuted if I make any fraudulent statement. I AGREE to supply any further information that may be requested of me in connection with my claim. I AUTHORISE any Doctor, Dentist, Hospital, Police, Allied Health Provider, Insurer, Company, Firm or Person to disclose to Echelon Claims Services/Underwriter any and all information that they may request in connection with this claim, and I ACKNOWLEDGE that if I revoke or withdraw this authority at any time, my claim will be invalidated.			
My Medicare Number:			
I AGREE that a photocopy of this Authorisation shall be considered to be effective and valid as the original I have read and accept the Privacy Statement provided with this claim form			
Signature of Claimant:		Date:	

STATEMENT OF CLAIM (To be completed by the claimant)				
1. When did the accident occur?				
Date:		Time:		am/pm
2. What is the date of the first day you were unable to work?				
3. (a) In your own words, please provide a FULL description of how the injury occurred and what you were doing at the time				
(b) During the 24 hours before the injury, did you consume alcohol or drugs?			YES ☐	NO ☐
If yes, please state types, quantities, and amount of time between last consumption and injury occurring				

STATEMENT OF CLAIM (To be completed by the claimant)						
(c) Were Police in attendance as a result of this accident?					YES ☐	NO ☐
If yes, please provide a copy of their report or the attending officer's name and Police Station						
(d) Please provide names and addresses of any witnesses						
(e) Was hospitalisation required?					YES ☐	NO ☐
If yes, name of Hospital:			Dates confined:			
Please also obtain and provide a copy of the emergency department Triage Report from the hospital						
(f) Was the use of an ambulance required?					YES ☐	NO ☐
4. Have you ever suffered from this or a similar injury in the past?					YES ☐	NO ☐
If yes, please provide details and dates						
5. Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?						
Third Party Insurance (Motor Vehicle Accident)	YES ☐	NO ☐	Centrelink or Other Government Benefits		YES ☐	NO ☐
Other Insurance/ Own Income Protection)					YES ☐	NO ☐
If yes, please provide details including Policy and Claim Number (and dates where applicable)						
6. Have you ever made a previous claim in respect to Accident Insurance?					YES ☐	NO ☐
If yes, please provide details including Insurer and Claim Number						

STATEMENT OF CLAIM (To be completed by the claimant)		
7. Have you engaged in any other income earning employment since you became disabled?	YES ☐	NO ☐
If yes, please provide details (Name of Employer and Payslips)		
8. Name of your Superannuation Fund and Member Number		
9. When did you, or when do you expect to resume work?		
Please provide your reasons explaining why you are unable to carry out your usual duties		
10. Do you consider yourself fit for alternative duties?	YES ☐	NO ☐
If yes, have you discussed the possibility with your employer and if so what was the outcome?		

DECLARATION OF PRE-DISABILITY EARNINGS BY EMPLOYER
Weekly earnings during the 14 weeks prior to incapacity – for employees
Employee's Name:
Please read the following definition of "Ordinary Time Earnings" before completing this form.
"Ordinary Time Earnings" means, the actual ordinary hourly rate of pay the employee receives for ordinary hours of work including, but not limited to, superannuation and redundancy fund allowance, tool allowance, industry allowance, trade allowances, shift loading, special rates, qualification allowances, (eg. first aid, laser safety officer), multi-story allowance, site allowance, asbestos eradication allowance, leading hand allowances, in charge of plant allowance, supervisory allowances and all other allowances applicable. Ordinary Time Earnings includes the base hourly rate of pay as set out in Schedule 2 of the EBA plus all-purpose allowances and any regular over Award payments, as well as, casual rates and any additional rates and allowances paid for work undertaken during ordinary hours of work, including fares and travel.

	Week Ending – DD/MM/YY	Gross Weekly Earnings as noted above + overtime (if applicable)
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
11		$
12		$
13		$
14		$
	TOTAL	**$**
	Average Weekly	**$**

Earnings during the fourteen (14) weeks prior to disablement must be provided. (Please note if cover is provided on a site specific basis, then only the earnings in relation to that site should be provided).

To avoid delays, please ensure that this form is fully completed with ALL "Ordinary Time Earnings" as detailed in definition above. Please note that Weekly Benefit entitlements will be calculated upon the information/declaration that you provide.

I sincerely DECLARE that to the best of my knowledge the information provided above is true, accurate and complete.

Payroll Officer's Name:	
Signature:	**Dated**:

DOCTOR'S STATEMENT (Please print legibly – this form cannot be accepted otherwise)

IMPORTANT

- The patient is responsible for any fee for this statement.
- This form can only be completed by the Treating Medical Practitioner or Surgeon (not Physiotherapist).
- Dashes or blank spaces are not acceptable.
- If the regular or usual doctor was not the treating doctor, this statement will also have to be completed by the claimant's regular doctor. If the claimant has been referred to another physician for treatment, a subsequent statement may be required to be completed by that physician.

Claimant's Full Name:

1.		How many years or months has the claimant been your patient / under your care?
2.	(a)	What date were you first consulted by the claimant in connection with the present Sickness or Accident? Date:
	(b)	How long had the patient been experiencing symptoms prior to consulting you for the first time?
	(c)	Are these symptoms consistent with the current diagnosis?
	(d)	When do you believe this condition first manifested?
3.	(a)	What is the exact nature of the present Sickness or Injury?
	(b)	If X-Ray examination or other tests have been made, state finding and/or quote report.
	(c)	What is the (proximate) cause of the disabling condition?
4.	(a)	Is the current condition in any way related to their work? Yes ☐ No ☐
	(b)	Would you support a Workers' Compensation claim? Yes ☐ No ☐
		If not, please explain why not -
5.		Has the patient previously suffered from the same or a similar condition? Yes ☐ No ☐
	(a)	Dates of consultations:
	(b)	Diagnosis:
	(c)	Was this occurrence/recurrence expected? Yes ☐ No ☐

	If so, why?
	(d) Do you expect any further recurrence of this condition? Yes ☐ No ☐
	If YES, please provide details:
6.	Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the Injury/ Sickness? Yes ☐ No ☐
	If YES, please provide details:
7.	Is there anything in the patient's medical history that may be likely to delay the recovery? Yes ☐ No ☐
	If YES, please provide details and advise how long recovery may be delayed:
8.	Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his/her current disablement:
9.	Do you consider treatment other than that being received is essential to recovery? Yes ☐ No ☐
	If YES, please provide details. How might this promote a return to work?
10.	Have you referred the patient to other specialist services or treatment? Yes ☐ No ☐
	If YES, please provide details and a telephone contact number -
11.	If the claimant has already been hospitalised, please give name of hospital and dates.

12.	Is treatment likely to be prolonged by any complications? Yes ☐ No ☐		
	If YES, please provide details and advise how long treatment may be prolonged:		
13.	Has the claimant continued to follow medical advice? Yes ☐ No ☐		
	If NO, please provide details:		
14.	Is there any reason or evidence to suggest the patient was under the influence of intoxicants at the time of the accident or that intoxicants may have caused the injury? Yes ☐ No ☐		
15.	(a) When was the claimant obliged to cease work?		
	(b) When did or when do you realistically expect the claimant to resume work? Date:		
	(i) Full unrestricted duties:		Date:
	(ii) Modified duties, if necessary:		Date:
	(iii) Normal duties in reduced capacity (i.e. restricted hours):		Date:
	If unable to return to work in a partial capacity, please provide an explanation.		
16.	I hereby certify that the patient has been and or will be totally disabled from carrying out his / her usual occupational duties as follows:		
	From:	To: (inclusive)	
17.	Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list)		
Doctor's Name:			
Doctor's Address:			
Telephone No:		Facsimile No:	
I hereby certify that I have personally examined the above-named claimant and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the Claimant's Injury or Sickness.			
I have read and accept the Privacy Collection Statement provided with this Claim Form.			
Signature:	**Qualifications:**	**Dated:**	

ECHELON AUSTRALIA PTY LTD

ABN 96 085 720 056

COLLECTION STATEMENT UNDER PRIVACY ACT 1988 (Cth)

In accordance with the Privacy Act 1988 (Cth) and any subsequent amendments (the Privacy Act), we Echelon Australia Pty Ltd (Echelon), including Echelon Claims Services, draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for any of the following purposes (depending on your requirements):
    - approaching the (re)insurance market;
    - placing insurance or providing alternative coverage;
    - assessing and advising you on your insurance or coverage needs;
    - providing claims handling or risk management services;
    - providing you with information about other JLT products or services; and
    - administering payments to you.
- The information we collect may be disclosed to third parties including but not limited to: (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and other Echelon related group companies, such as JLT Risk Solutions Pty Ltd and JLT Group Services Pty Ltd. Echelon is a business of Marsh and McLennan Companies (MMC). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia). It may also be sent to: Bermuda, Brazil, China, Dubai, Hong Kong, Ireland, Japan, Singapore, South Korea, United Kingdom and the United States for the purposes of outsourcing Insurance Broking, Intermediary and Risk Advisory Services; and Canada, India, United Kingdom and the United States for the purposes of outsourcing Business Support Services (for example, IT systems administration and payment processing).
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act, you must obtain it with the individual's consent.
- By providing this information, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application or claim or provide other required services.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- We will use and disclose your personal information in accordance with our Privacy Policy. Our Privacy Policy can be accessed on our website (https://www.echelonaustralia.com.au/privacy).
- For further information contact your Account Executive, Claims Manager or our Privacy Officer at the following address:

  Echelon Australia Pty Ltd, One International Towers, 100 Barangaroo Avenue, SYDNEY, NSW, 2000.
  Telephone: +61 (02) 8864 7688. Email: privacy.australia@marsh.com