# NOTICE OF CLAIM FORM

This form was approved by the CTP regulator for the purposes of section 276 of the Road Transport (Third-Party Insurance) Act 2008 (prescribed by section 84 (Notice of Claim)).

### **Protection of Privacy**

• The information collected by this Notice of Claim, and throughout the course of your claim, is collected in accordance with the *Road Transport (Third-Party Insurance) Act 2008* (the Act) and Road Transport (Third-Party Insurance) Regulation 2008 (the Regulation).

• The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to assist the CTP regulator with the administration of the statutory insurance scheme, including the detection of fraud and conducting research. This may include the CTP regulator contacting you to discuss your own claim experience.

• The information collected by this Notice of Claim Form and throughout the course of your claim may be disclosed in accordance with the Act and the Regulation to such bodies as: the CTP regulator, the Nominal Defendant, and other insurers or parties involved in the assessment of your claim, such as those indicated below.

• Failure to provide all or part of the information may delay or prevent the assessment of your claim.

• You are able to gain access to personal information held as provided by the *Privacy Act 1988* (Cth), or if the information is held by the ACT Government, as provided by the road transport legislation and the *Information Privacy Act 2014* (ACT).

• Any personal information you provide to the CTP Insurer will be collected, held, used and disclosed in accordance with their Privacy Policy. You will be able to view their privacy policy on their website or you can request that the Insurer send you a copy.

If you have already completed a Motor Accident Notification Form (MANF) and your doctor has completed the Motor Accident Medical Report (MAMR) section, please attach a copy of your signed MANF/ MAMR to this Form, and complete this Notice of Claim Form.

MANF / MAMR	CTP Claim Number:
CTP Insurer	(if known)

If you have not already completed the MANF/ MAMR form, please do so. Once this form is completed and signed, attach it to the completed Notice of Claim Form. The Notice of Claim Form is to be submitted to the CTP Insurer of the at-fault vehicle. Time limits apply. If you are submitting your Form after the relevant time period that applies to your claim, attach an explanation for the delay to this Form.

## Part A: Your details

Title	Mr Other	Mrs	Ms	Dr	
Full Name					
Street Address					
City		Stat	te		Post code
E-Mail Address					
Date of accident					
For help with th	is form in a land	uage other tha	n English pleas	e call the Telephone In	terpreter Service (TIS) on 131 450.

## Part B: Employment Details

Employment status at the time of the accident	Full Time Employed Self-Employed Retired Student/Child Pension If pension or other please describe:	Casual Part Time Employed Home Duties Not Working Other		
Occupation/ Job				
Employer		Name of business		
Business contact person			Phone No.	
Address				
Description of work duties				
	kers' compensation or will th . public liability) as a result o	•	Yes No	
	If yes, insurance compa claim number (if k			
Earnings prior to the	e accident			
Usual Weekly Working	g <u>Hours</u>			
Ordinary hours	Ove	r time hours (if applicable)		
Average Weekly Earn	ings prior to the accident (ind	cluding overtime, regular bon	uses and commissions)	
Gross earnings (before tax)	Ne	et earnings (after tax)		
Lost earnings/Return	n to Work			
Have you lost		s, please		
any income as a result of this accident?	No provid	e details		
Have you		eturned	Date expected	
returned to work?	No	to work	to return to work	
Self-Employed claimants ONLY				
Business Name				
Principal Address				
ABN		Nature of Business		
AF2016-98	Authorised by the ACT Parliamenta	ary Counsel—also accessible at www.legi	slation.act.gov.au	

Accountant's			Phone	
Name			Number	
Accountant's				
Address				
Details of				
replacement				
labour				
rt C: Legal Re	presentation			
rt C: Legal Re	presentation Do you have a solicitor acting for your claim?	Yes	No	
	-	Yes	No	
rt C: Legal Re Name of Firm Name of	-	Yes	No	
Name of Firm	-	Yes		
Name of Firm Name of	-			

It is an offence under section 116 of the Road Transport (Third-Party Insurance) Act 2008 to provide false or misleading information. You can be fined up to 100 penalty units and/ or be imprisoned for up to 1 year. By signing the declaration you are declaring the information provided is true, correct and complete. As at 1 July 2016 a penalty unit was \$150 for an individual; the maximum fine would be \$15,000. For up to date information on the value of a penalty unit, see section 133 of the Legislation Act 2001.

Declaration

solicitor

name

claimant

AF2016-98

Relationship to

Previous name

(if applicable)

I intend to proceed with a claim under section 84 of the Act. I confirm that the information provided in this form is true and correct to the best of my knowledge.

- Signature claimant or agent		Date	
Print Full name of Claimant			
Signature of witness		Date	
Print Full name			
This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant is unable to sign, this form must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf the claimant). Please provide details of the person who signs as agent of the claimant below			

low: Date of Birth Agent's full

Contact no.

Reason(s) cannot

sign

Authorised by the ACT Parliamentary Counsel-also accessible at www.legislation.act.gov.au

### Authority to obtain information

For the purpose of assessing my claim, I hereby authorise the Insurer against whom this notice is made, to contact and obtain information and documents relevant to my claim under the *Road Transport (Third-Party Insurance) Act 2008*, for injury sustained in the accident which occurred on the date recorded in Part A of this form as follows:-

1. Clinical notes in the possession of a health service provider who treated or assessed me in relation to the personal injury ("injury").

2. Medical reports from health service or rehabilitation providers who have treated or assessed me for my injuries, or any pre-existing injury or condition exacerbated by the accident.

3. Clinical notes in the possession of any hospital (including any private hospital) where I received treatment relevant to the injury.

4. Records in the possession of an Ambulance or other emergency service that treated or assisted me in relation to the injury.

5. Clinical notes in the possession of a health service provider or hospital which treated or assessed me for the pre-existing injury or condition exacerbated by the accident.

6. Wage, leave and work history records in the possession of (i) my employer, (ii) anyone else who employed me at any time during the 3 years before the accident; or my accountant (if self-employed).

7. Any records concerning me in the possession of an insurer carrying on the business of providing CTP insurance or Workers' Compensation insurance, regarding any previous or concurrent claims, or insurance against the loss of income through disability.

8. Records from any of the following:

• other licensed insurers;

• a department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;

• a doctor, professional provider of rehabilitation services or person professionally qualified to assess cognitive, functional or vocational capacity, and

• an educational institution.

(Note: An insurer includes a reinsurer and/or overseas reinsurer).

I, the claimant (or their agent) signed hereunder, declare the information provided is true and correct, that I understand this authorisation and that this authority is provided for by legislation and the consent provided in this authority cannot be withdrawn.

Signature - Date Of Date of Date of Birth

Print Full name of claimant

This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant is unable to sign, this form must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf the claimant). Please provide details of the person who signs as agent of the claimant below:

Agent's Full Name

Relationship to claimant

Previous name (if applicable) Reason(s) cannot sign

Date of Birth

Contact no.

4