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Motor Accident Commission (MAC)

INJURY CLAIM FORM

Instructions

Please complete and return the attached form to Liptak Lawyers

1. Email: info@liptak-lawyer.com.au
2. Mail: 262 Melbourne Street, North Adelaide SA 5006

About me

Office Use: Claim Number

Personal details

1 Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Surname

Given names

Have you been known by another name? Yes ☐ No ☐

If yes, surname

Given names

2 Male ☐ Female ☐

3 Date of birth / /

Country of birth

4 Language spoken at home

5 Do you require an interpreter? Yes ☐ No ☐

6 Home address

Postcode

Postal address (if different to the above)

Postcode

7 Home phone no ( )

Work phone no ( )

Mobile no

Email

8 Medicare no

9 Driver's Licence number

State Expiry date / /

Please attach a copy of your Driver's Licence

10 Occupation

Name of employer(s)

Work address(es)

11 Are you receiving or entitled to any type of benefit or other compensation? Yes ☐ No ☐

If yes, please indicate below

☐ Centrelink (type)

☐ Workers Compensation (name of Workers Compensation insurer, exempt employer or claims agent)

☐ Invalid / Disability Income Protection (name of insurer)

☐ Other (details)

12 Have you had any injuries or illness – before or since the accident – to the same part(s) of your body? Yes ☐ No ☐

If yes, please include approximate date, injury or illness, treating doctor etc, as appropriate.

13 Have you been involved in ANY accidents in which you were injured prior to or since this accident? (e.g. motor vehicle accident, sports, work, home) Yes ☐ No ☐

If yes, please include approximate date of injury, treating doctor, type of claim, insurer etc as appropriate. You should also advise the approved CTP insurer if you have another accident while your claim is progressing.

14 Have you made any kind of personal injury or illness claim before? Yes ☐ No ☐

If yes, please include approximate date, injury or illness, treating doctor, type of claim, insurer etc as appropriate.

15 Name of person completing the form (if not injured person)

Relationship to injured person

Reason why injured party is not completing this form?

About my accident

Accident details

16 Were you a Driver/Rider ☐ Cyclist ☐
Passenger/Pillion ☐ Pedestrian ☐ Other ☐

17 Date of accident / / Time of accident am/pm

Weather

Road conditions

Place of accident

Suburb Postcode

18 How many vehicles were involved in the accident?

If you were a cyclist or pedestrian, please go to second vehicle, Question 20

19 Nominate the at fault motor vehicle (registration) you consider caused the accident.

First vehicle

20 Details of vehicle you were travelling in.
Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Driver Surname

Given names

Driver phone no ( )

Driver address

Postcode

Registration no

State of registration

Year (e.g. 1990)

Make and model (e.g. Mazda 6)

Body type (e.g. Sedan)

Colour

Second vehicle

21 Details of other vehicles involved in the accident (if known).
Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Driver Surname

Given names

Driver phone no ( )

Driver address

Postcode

Registration no

State of registration

Year (e.g. 1990)

Make and model (e.g. Mazda 6)

Body type (e.g. Sedan)

Colour

Please continue on Page 11 if there are more than 2 vehicles involved.

Witness(es) details

22 Were there any witness(es) Yes ☐ No ☐ Unknown ☐
If yes, please give details below
If no, please go to Question 22

Witness 1
Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Witness Surname

Given names

Witness phone no ( )

Witness mobile

Witness address

Postcode

Witness 2
Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Witness Surname

Given names

Witness phone no ( )

Witness mobile

Witness address

Postcode

Police report

23 Did the Police come to the scene of the accident?
Yes ☐ No ☐ Unknown ☐

Did you report the accident to the Police? Yes ☐ No ☐

Police Report no

Police station

24 Is Police action going to be taken? Yes ☐ No ☐ Unknown ☐
If yes, name of person charged

Offence charged

Circumstances of accident

25 Were you wearing a properly adjusted and fastened seat belt?
Yes ☐ No ☐ Not applicable ☐
If not applicable, please give details

26 If you were on a bicycle or motorbike, were you wearing a fastened safety helmet? Yes ☐ No ☐
If yes, was it securely fitted? Yes ☐ No ☐

27 Had you had any drugs, including medication or alcohol, in the 12 hours before the accident? Yes ☐ No ☐
If yes, please give details of how much, what and when

28 (i) Did you have a breathalyser test conducted? Yes ☐ No ☐ Unknown ☐

If yes, provide result(s) and attach docket if provided

(ii) Was a drug test conducted? Yes ☐ No ☐ Unknown ☐

If yes, what was the result?

(iii) Did you go to hospital? Yes ☐ No ☐ Unknown ☐

(iv) Did you have a blood sample taken? Yes ☐ No ☐ Unknown ☐

If yes, please provide result and attach certificate (both pages)

If not available please provide at first available opportunity

29 If you were a passenger in a vehicle, or a passenger on a motorbike, had the driver or rider had any alcohol and/or drugs, including medication in the 12 hours before the accident? Yes ☐ No ☐ Unknown ☐

If yes, please give details – how much, what and when

30 Please mark with a ✓ your position in or on the vehicle.

31 Description of the accident. *(Describe how the accident happened and include a reference to road conditions, speed, traffic lights, road signs, peak hour etc and details of vehicle damage).*

Please continue on Page 11 if you need to include more information.

32 Diagram of accident. *(Please draw a diagram of the accident. Include intersections, streets, roads and their names. Show the point of impact and position of all vehicles).*

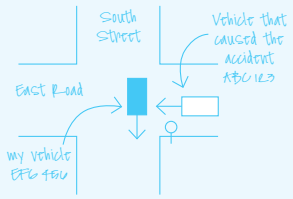
Symbols to use

traffic sign — traffic lights

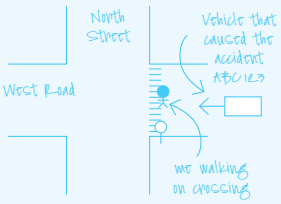
witness — pedestrian

your vehicle (black) — other vehicles 1, 2, 3

Example diagram for vehicle



Example diagram for pedestrian/cyclist



Check list

Please show ☐ street names ☐ lanes/lines markings ☐ traffic signals/signs

Vehicle 1 registration

Vehicle 2 registration

Vehicle 3 registration

About my injuries

Injuries

33 What are your injuries from the accident?
(List all injuries. Please continue on Page 11 if you need to include more information).

Treatment

34 Were you taken by ambulance from the accident scene? Yes ☐ No ☐

35 Did you go to hospital? Yes ☐ No ☐
If yes, please give details

Name of Hospital

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

If admitted, admission date / / discharge date / /

36 Did you seek treatment from a private doctor? Yes ☐ No ☐
If yes, please give details

Doctor's name

Date of visit / /

37 Who has treated you for your injuries since the accident?
(List all doctors, surgeons, physiotherapists, specialists, etc. Please continue on Page 11 if you need to include more information).

(i) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

(ii) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

(iii) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

38 Are you still receiving treatment? Yes ☐ No ☐
If yes, please give details (e.g. physiotherapy, chiropractic, etc, including name and address).

How long do you expect treatment to continue?
Days ☐ Weeks ☐ Months ☐ Longer ☐

39 How do the injuries affect you NOW?
(Please continue on Page 11 if you need to include more information.)

About my claim

(You will need to supply a medical certificate or opinion from your doctor to support your claim)

Medical expenses

40 Have you incurred any medical expenses? Yes ☐ No ☐

Please attach all accounts you have to this claim form for consideration by the approved CTP insurer

Income

41 Have your injuries prevented you from working in your normal duties?

Yes ☐ No ☐

If no, go to Question 47

If yes, please explain how

42 Date you stopped work or were prevented from performing your normal duties due to the accident / /

43 Have you returned to work? Yes ☐ No ☐

44 Have you returned to normal pre-accident duties and hours? Yes ☐ No ☐

If no, please provide details

45 Are you employed? Yes ☐ No ☐

If no, please go to Question 46

Occupation

Name of employer

Contact person's name

Contact phone no ( )

Work address

Postcode

Usual weekly working hours Overtime

Usual weekly earnings *(including overtime, regular bonuses & commission)*

Gross pay $ Net pay $

Please describe your duties

Details of lost income *(please attach payslips or group certificate)*

Name of other employer (if applicable)

Contact person's name

Contact phone no ( )

Work address

Postcode

Usual weekly working hours Overtime

Usual weekly earnings (including overtime, regular bonuses & commission)

Gross pay $ Net pay $

Please describe your duties

Details of lost income *(please attach payslips or group certificate)*

46 Are you self-employed? Yes ☐ No ☐

If no, please go to Question 47

Occupation

Work address

Postcode

Usual weekly working hours

Usual weekly earnings $

Please describe your duties

Details of lost income *(please attach your most recent notice of assessment or financial statement)*

Other losses

47 Have you suffered any other losses or incurred other expenses relating to this claim (excluding damage to your vehicle or personal items) that you wish to have considered (eg. assistance at home or travel for treatment)? Yes ☐ No ☐ Unknown ☐

If yes, please provide details

Statement giving authority to obtain information

Schedule 1 – Motor Vehicles (Third Party Insurance) Regulations 2013

By completing this authority to obtain information (the authority) you are giving the approved CTP insurer that is managing your claim, permission to obtain documentary information relevant to processing and assessing your claim.

I *(please print)* .....

date of birth / /

authorise the approved insurer that is managing your claim and its agent/s to obtain documentary information relevant to my claim for damages or other compensation *(specify)*:

.....

sustained on or about (date) / /

from the following people/organisations, and for those people/organisations to disclose such information to the approved CTP insurer:

.....

(a) insurers that carry on the business of providing -
  (i) compulsory third party insurance; or
  (ii) private health insurance; or
  (iii) motor vehicle insurance; or
  (iv) workers compensation insurance;
(b) health practitioners;
(c) hospitals, including private hospitals;
(d) ambulance or other emergency services;
(e) professional providers of rehabilitation services or persons professionally qualified to assess cognitive, functional or vocational capacity;
(f) educational institutions;
(g) my employer or my previous employer;
(h) departments, agencies or instrumentalities of the Commonwealth, the State or another State, administering laws about health, police, transport, taxation or social welfare;
(i) the Lifetime Support Authority of South Australia;
(j) ReturnToWorkSA.

I approve a copy of the authority, including an electronic version, being treated as the original.

This authority is valid for the duration of my claim (unless revoked after the expiration of 6 months from the date of execution of the authority).

Signed

.....

Date / /

Details and signature of witnessing party (any person over 18 years of age)

Full name of witness .....

Signature of witness

.....

Date / /

Note:

1. If you wish to make a claim for damages or compensation you must sign this authority. This is required by law.
2. This authority will remain in force until your claim is resolved or you revoke it. However, you can not revoke this authority for at least 6 months after you sign it.
3. Prior to using this authority to obtain information, the approved CTP insurer, nominal defendant or agent must ensure the authority is valid and the information is relevant.
4. The claimant has the right to seek independent legal or other advice before signing the authority. You will be responsible for paying any fee for the advice.
5. The approved CTP insurer/nominal defendant or claims agent must provide you with a copy of any documents that they obtain under this authority within 21 days of receipt of those documents.

Acknowledgement

Questions in this form requesting information as to fault are not required by statute, and do not require you to assess who is at fault as a matter of law. You are requested to provide this information simply to assist with initial administration of the claims process.

Any information provided on this form as to fault is indicative only and can not constitute an admission of fault or wrongdoing by any person for legal purposes.

Declaration

Please read the Declaration carefully before signing.

It will assist us in dealing with your claim if the declaration is properly completed and witnessed.

The injured person should sign the declaration unless he/she is under 18 years of age or is unable to make the declaration. In this case a parent or guardian of the injured person should sign the declaration.

All information you have given in the claim form must be true and correct in every respect.

Under Section 124(6a) of the *Motor Vehicles Act 1959*, you can be fined up to $50,000 or be imprisoned for up to one year for knowingly providing false or misleading information.

I (full name) .....

declare that, to the best of my knowledge, the information given in this Claim Form is true and correct in every respect.

Signature of claimant

.....

(Parent or guardian must sign if claimant is under 18 years of age)

Date / /

Details and signature of witnessing party (any person over 18 years of age)

Full name of witness .....

Signature of witness

.....

Date / /

Nominee Authority

Authority to communicate directly with nominee. Please complete this if you need the approved CTP insurer to communicate with your nominee.

I authorise the approved CTP insurer that is managing your claim (or its agents) to communicate directly with my nominee (as detailed below).

This authority will extend to, but is not limited to, discussing relevant private matters and supplying and receiving oral and written information and will remain in force until withdrawn by me in writing.

Signature of claimant

.....

Date / /

(Parent or guardian must sign if claimant is under 18 years of age)

Witness details .....

Name .....

Signature

.....

Date / /

To be completed by nominee

I ..... (name)

of .....

..... (address)

accept the role of communicating on behalf of the above claimant with the approved CTP insurer and undertake to keep confidential (other than with the claimant) any information gathered while occupying this role.

Signature of nominee

.....

Date / /

Witness details .....

Name .....

Signature

.....

Date / /

Additional space

Space used for further information

Please attach extra pages if required

ATTENTION

We appreciate that your time is valuable; however the more information you can supply at this stage will assist us in processing your documentation.

Please ensure you have completed the following:

- ☐ Reported the accident to the police.
- ☐ Nominated the at fault motor vehicle (registration) and person you consider caused the accident.
- ☐ Signed the declaration on Page 10 in the presence of a witness over the age of 18.
- ☐ Attached proof of age if you were under 18 years of age at the date of accident.
- ☐ Attached medical certificate or opinion from your doctor.
- ☐ Attached to the claim form any original accounts, receipts or invoices you may already have.
- ☐ Attached proof of income (if relevant).
- ☐ Made a copy of the claim form, medical certificates, accounts, invoices, etc for your own record.
- ☐ Attached a copy of your driver's licence (or other proof of identity), breath analysis and/or drug analysis docket, or Blood Alcohol certificate (2 pages) where available.

Please ensure that all other sections of the form/s are completed to the best of your ability.

If you have any questions about the completion of the forms please contact the CTP Insurance Regulator on 1300 303 558 and we will be happy to assist with your enquiry.