



LIPTAK
LAWYERS

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

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 / /



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.