1. Member Details

Given Name (s) *

Surname *

Date of Birth *

Sex

AMWU Membership No.

Employer

Residential Address *

Street address *

City *

State *

Please select

Postcode *

Phone (home)

Phone (mobile)

Email Address *

Occupation prior to disablement *

Please describe your usual duties *

2. Injury Description

Please give a full description of the injury suffered *

Have you ever suffered a similar injury before? *

- ◯ Yes
- ◯ No

If yes, please provide the nature of the condition(s) and relevant dates

3. Payment Details

Account Name *

Bank *

BSB *

Account Number *

Tax File Number *

Please note you will need to provide a completed Tax Declaration with your claim for Tax to be deducted from benefits. You can do this via: **https://www.ato.gov.au/forms-and-instructions/tfn-declaration** (https://www.ato.gov.au/forms-and-instructions/tfn-declaration)

4. Journey Details

Where did the accident occur? *

What address did the journey commence from? *

Street address *

City *

State *

Please select

Postcode *

What address were you travelling to? *

Street address *

City *

State *

Please select

Postcode *

Date journey commenced *

Time journey commenced (AM/PM) *

Were you travelling to or from work? *

- Yes
- No

Was this your usual route? *

- Yes
- No

Please describe the route and method of transport taken *

Did you divert from your usual route? *

- Yes
- No

If you answered yes, please provide details

Was the journey broken for any reason? *

- Yes
- No

If yes, please explain

5. Accident Details

Date of accident *

Time of accident *

How did the accident occur? *

Can you please provide the names and addresses of witnesses *

In your opinion, who was responsible and why? *

6. Medical and Work Capacity

When did you first consult a doctor for this condition? *

When did you become totally unable to work? *

If still incapacitated, what is your expected date of return to work?

If returned to work, date partial duties resumed

If returned to work, date partial full duties resumed

7. Other Insurance or Compensation

Are you making or intending to make any other claim in respect of this disability? *

- [ ] Workers Compensation
- [ ] Government Benefits
- [ ] Motor Accident
- [ ] Other
- [ ] No other claim

If you selected any of the above, please provide more details (E.g. Insurer, claim number)

8. Employment Details

Name of Employer *

Date of employment *

Average weekly earnings *

Date of disablement from work *

Please provide a copy of your 12 month pay report from your employer *

Browse

9. Privacy Statement and Declaration

Privacy Statement

We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyds of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, you can access a copy of our Privacy Policy on our website **www.coverforce.com.au** or alternatively contact our Privacy Officer on **02 9376 7888**.

- [ ] I have read and understood the privacy information provided above

- [ ] I authorise Coverforce and their representatives to obtain medical, employment and financial information relevant to this claim. I declare that the information provided is true and correct and acknowledge that if I make false or fradulent statements of fail to advise the AMWU of any relevant information regarding my claim, the AMWU may refuse to pay, and cancel my claim. *

Name *

Date *

Draw signature | Type signature Clear

Section B: Medical Practitioner's Statement

Section B is to be completed by your treating doctor. All certificates and evidence required shall be furnished as required at the claimant's expense.

1. Patient Details

Title

Given name(s)

Surname

Date of birth

Height

Weight

How long has the patient been attending your practice?

Sex

Male Female

2. Medical and Consultation Details

What is your diagnosis of the patient's injury?

What is the patient's current treatment program? (e.g. medication, surgery, physio, exercise etc.)

What is the cause of the disabling injury? Please provide reasoning for your response.

To your knowledge, on what date did the patient first seek treatment or advice for treatment from a legally qualified medical practitioner in relation to this condition?

On what date did you first consult the patient in relation to this condition (if different from above)

Have you at any time advised the patient that they can cease all treatment for this condition?

- ◯ Yes
- ◯ No

Please provide any relevant medical history that may assist us with this claim

What investigations have been undertaken in determining a diagnosis?

Please upload/attach copies of any pathology reports/investigations

Browse

Please upload/attach copies of any pathology reports/investigations

Browse

Please upload/attach copies of any pathology reports/investigations

Browse

Please upload/attach copies of any pathology reports/investigations

Browse

Please supply the names, specialties and contact details of doctors that the patient has been referred to for this condition

Doctors name & specialty

Period of attendance (from)

Period of attendance (to)

Phone

Add doctor

Do you consider the patient to be/has been wholly and continually prevented from engaging in his/her usual occupation as a result of this condition?

Yes No

If yes, for what period? (DD/MM/YY)

Do you consider the patient is/has been unable to carry out a substantial part of his/her usual occupation as a result of this condition?

Yes No

If yes, for what period? (DD/MM/YY)

If no, has there been or will there be any period of disablement as a result of this condition?

Yes No

If yes, for what period? (DD/MM/YY)

Please specify reason(s)

Estimated date of return to work

3. Privacy Statement

We are subject to the Australian Privacy Principles as per the Privacy Act 1988 (Cth) (the Act). We collect your personal information to enable us to provide, offer and administer our products and services or otherwise as permitted by law. Reasons for collection include, but are not limited to, responding to your enquiries, providing you with assistance you request us, maintaining and administering our products and services (for example, processing requests for quotes, applications for insurance, offering insurance terms or any other purpose identified at the time of collecting your information). We may be required to disclose your information to third parties to assist with your insurance needs (this can include disclosure to an overseas insurer such as Lloyd's of London or insurer).

You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or on our website **www.coverforce.com.au**.

Name

Qualifications

Phone Number

Email Address

Address

Draw signature | Type signature Clear

Date

info@coverforce.com.au

coverforce.com.au

Level 17, 201 Elizabeth Street, Sydney NSW 2000

Locked Bag 5273, Sydney NSW 2001

P: 13000 COVER **F:** 02 9223 1422

Submit

Save and Complete Later