Journey Claim – Supplementary Report
Claimant Statement

Claimants name:

Claim number:

Union Membership Number:

This form relates to period (DD/MM/YY):

to

Postal address:

Suburb:

State:

Postcode:

Phone:

Treating doctor:

Phone:

What condition(s) is/are currently preventing you from performing work-related duties?

What treatment(s) are you currently undertaking for the above reported condition(s)?

☐ Physiotherapy
☐ Rehabilitation

☐ Gym-based exercise
☐ Supervised

☐ Alternative therapy (please specify):

☐ Hydrotherapy
☐ Surgery

☐ Unsupervised
Days per week:

☐ Other (please specify):

Surgery:

Medication (please specify):

Review date with Doctor

General Practitioner name:

Next review date (DD/MM/YY):

Specialist name & specialisation:

Next review date (DD/MM/YY):

Specialist name & specialisation:

Next review date (DD/MM/YY):

What improvements have been made in the past 4-6 weeks?

Has anything happened to prolong recovery of your condition? ☐ Yes ☐ No

If Yes, please provide details:

In your own words please describe what activities you are able to perform (include work and home duties):

What is your current employment status?

☐ Employed ☐ Resigned ☐ Terminated ☐ Other (please specify):

Are you currently fit to perform light duties at work?

☐ Yes; please ask your doctor to fill in only the Partial Incapacity Section

☐ No; when do you estimate you will be fit for:

Suitable/alternative duties?	☐ <1 month	☐ <1-2 months	☐ <2-6 months	☐ <6-12 months	☐ <12+ months
Full duties?	☐ <1 month	☐ <1-2 months	☐ <2-6 months	☐ <6-12 months	☐ <12+ months

Have you received any payment from any other sources during your disability? ☐ Yes ☐ No

If Yes, please provide details:

ALL INFORMATION THAT I/WE HAVE GIVEN IN THIS STATEMENT IS TRUE AND CORRECT.

Name: Signature: Date (DD/MM/YY):

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 Lloyd's 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 coverforce.com.au or alternatively contact our Privacy Officer on 02 9376 7888.

Journey Claim – Supplementary Report
Attending Physicians Statement

Patient's name:

Date of birth (DD/MM/YY):

Patient's Condition
What is the condition currently disabling your patient?

Treatment
Has your patient undergone any treatment(s) in the past 4-6 weeks? ☐Yes ☐No

If Yes, please provide details:

To the best of your knowledge, is your patient compliant with the prescribed treatment? ☐Yes ☐No

Medical Status
Has there been a change in your patient's condition in the past 4-6 weeks? ☐Yes ☐No

If Yes, please provide details:

Has anything happened to prolong recovery of the disabling condition?
(e.g. underlying/ subsequent conditions, drug reactions) ☐Yes ☐No

If Yes, please provide details:

Has your patient provided you with a copy of their job description? ☐Yes ☐No

CDS Physicians Statement *Cont.*

Current Capacity - Total Incapacity (please only complete either the Total Incapacity or Partial Incapacity section as applicable)

Current period of Total Incapacity (DD/MM/YY):

	to	

When do you estimate the claimant will be fit for:

Suitable/alternative duties?	☐ <1 month	☐ <1-2 months	☐ <2-6 months	☐ <6-12 months	☐ <12+ months
Full duties?	☐ <1 month	☐ <1-2 months	☐ <2-6 months	☐ <6-12 months	☐ <12+ months

Current Capacity - Partial Incapacity (please only complete either the Total Incapacity or Partial Incapacity section as applicable)

Current period of Partial Incapacity (DD/MM/YY):

	to	

Is the claimant able to carry out all their pre-disability duties, but restricted with the number of hours and/ or days they work?

☐ Yes

☐ No (please specify): Hours per day: Days per week:

Please provide details of your patient's abilities/restrictions in the table below:

Activity:	Able to perform?	Capacity (hrs/mins/weight):	Breaks required every (hrs/mins):
Standing	☐ Yes ☐ No		
Walking	☐ Yes ☐ No		
Climbing stairs	☐ Yes ☐ No		
Descending stairs	☐ Yes ☐ No		
Crawling	☐ Yes ☐ No		
Squatting	☐ Yes ☐ No		
Bending	☐ Yes ☐ No		
Kneeling	☐ Yes ☐ No		
Sitting	☐ Yes ☐ No		
Keying	☐ Yes ☐ No		
Repetitive movements	☐ Yes ☐ No		
Operating machinery	☐ Yes ☐ No		
Lifting (weight)	☐ Yes ☐ No		
Lifting (at height)	☐ Yes ☐ No		
Travelling	☐ Yes ☐ No		
Driving	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

I HEREBY CERTIFY THAT I HAVE PERSONALLY EXAMINED THE ABOVE MENTIONED PATIENT AND THE INTION GIVEN IS ACCURATE AT THE TIME OF EXAMINATION.

Name:	Signature:	Date (DD/MM/YY):

Address:	Phone:	Fax:

Qualifications:

Please check you have correctly filled out all sections and saved the document before submitting the form.

Submit Form >>

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