Insurer's Claim Reference Number

Queensland Compulsory Third Party Insurance (CTP)

Notice of Accident Claim Form

(Non-Fatal Injury)

for accidents occurring on and after 1st October 2000

Motor Accident Insurance Act 1994

Important Notes:

- *The medical certificate in this form is to be completed by your doctor.*
- *Police report information is required to complete this form.*
- *The statements of fact contained in this notice of accident claim must be true, correct and complete. Before you sign the form read it carefully. Your signing of this form is to be witnessed by a person over the age of 18 years and to whom you are known.*
- *Severe penalties apply where false or misleading information is given in CTP scheme claims.*
- *If there is insufficient space to provide the required information, use the additional information page at the back of this form and/or attach additional pages.*

MAIC form 01-02

What you need to do

Police Reporting

- There must be an official Police record of the motor vehicle accident before you complete this form. Ensure that you have the Police accident report reference number.

Information/CTP Helpline

- If you need any assistance with the completion of this form, information on the claim procedure or other information on the CTP scheme, then contact the CTP Helpline on 1300 302 568.
- The regulatory authority for the CTP scheme is the Motor Accident Insurance Commission which can be contacted by mail at GPO Box 1083, Brisbane Q 4001; by telephone on (07) 3227 8088; by fax on (07) 3229 3214; or on the Internet at www.maic.qld.gov.au

Complete This Form/Where to Send It

- Use this form **if you personally suffered an injury** in a motor vehicle accident which was wholly or partly the fault of some other person.
- Use this form **on behalf of an injured person** who is unable to personally complete the information. (All of the answers to questions contained in the form must relate to the injured person.)
- To make a claim as a relative/dependant, for loss resulting from a person sustaining a **fatal injury**, use the Motor Accident Fatal Injury Notice of Claim Form (not this form).
- There is a **medical certificate** at the back of the form that must be completed by your doctor before lodging this form.
- Send the completed form to the **insurer** of the motor vehicle at fault. To obtain the name and address of that insurer, **contact the CTP Helpline**. When calling, you should have details of the accident and the registration number of the motor vehicle/s owned/driven by the person/s at fault. This information will assist the search.
- If the motor vehicle at fault is **uninsured (unregistered) or unidentified**, send the completed form to the **Nominal Defendant**, GPO Box 2203, Brisbane Q 4001. Unless indicated otherwise, the term insurer, when used in CTP claims, includes the Nominal Defendant.

Time Limits

- **Lodge this form with the insurer** (or, if the motor vehicle is **uninsured/unregistered**, the Nominal Defendant) as soon as possible. Your claim could be rejected if the insurer or the Nominal Defendant receives it more than **nine (9) months** after the date of accident or the first appearance of symptoms of the injury.
- **If an unidentified motor vehicle is involved in the accident**, this form must be lodged with the Nominal Defendant within **three (3) months** of the date of accident, unless there is a reasonable excuse for the delay. **In any circumstance**, your claim must be lodged with the Nominal Defendant within **nine (9) months** of the date of the accident or it will be **barred**.
- **If you retain a solicitor/lawyer, then within one (1) month of the first consultation with the solicitor/lawyer**, this claim form must be given to the insurer against whom the claim is to be made. This does **not** extend any of the time limits referred to above.

  Late lodgement: *If notice is not given within the time fixed by the Motor Accident Insurance Act 1994, your excuse for the delay must be given in the Additional Information/Excuse for Delay section at the back of this form or by separate notice to the insurer.*

What Happens Then

- **The insurer is required to contact you within fourteen (14) days** of receiving your claim form fully completed, with a decision on whether or not your claim form is a satisfactory notice and whether or not the insurer is prepared to meet your reasonable and appropriate rehabilitation expenses.
- **You must be prepared to help the insurer with its consideration** of your claim. You may be required to give specific information, photographs, documents or records, and you may have to have a medical examination or assessment. **You must also take all reasonable steps** to recover from your injury by having reasonable and appropriate treatment and rehabilitation, and to reduce your lost income – for example, by seeking alternative work.
- **If your claim can be finalised, you can discuss this with the insurer and agree on the payment to you**. If you are unsure of your legal rights, a solicitor/lawyer can advise what needs to be done and how much it will cost. The CTP Helpline may also be able to offer guidance to you.

1. Injured Person

Surname/family name

Given names

Ever been known by any other name? ☐ Yes ☐ No

If "Yes," advise other surname/family name

Other given names

Gender ☐ Male ☐ Female

Date of birth / / DD/MM/YYYY

Marital status ☐ Single ☐ Married ☐ De Facto

Home address | Suburb/town | State | Postcode

Business address | Suburb/town | State | Postcode

Postal address | Suburb/town | State | Postcode

Telephone

Home ( ) | Work ( ) | Mobile

Employment status at date of accident ☐ Employed ☐ Retired ☐ Home duties ☐ Student/child ☐ Not working

Occupation (If employed) at date of accident

Do you have any personal injury, illness or disability (either before or since the accident) that may affect the extent of the disability resulting from the personal injury to which this claim relates or may affect the amount of damages in any other way? ☐ Yes ☐ No

Have you ever sustained a *significant disability? ☐ Yes ☐ No

For a *significant disability, have you ever:

– made a claim for damages, social security benefits or compensation? ☐ Yes ☐ No

– received any amount by way of damages, social security benefits or compensation? ☐ Yes ☐ No

*Significant disability means *any personal injury, illness or disability that either:*

– *may be relevant to the assessment of the extent of the injury suffered by the injured person in the accident; OR*
– *lasted (or its symptoms lasted) for four (4) weeks or more.*

If Yes to any question, please provide details of the injury, illness, disability, damages, benefit and/or compensation

2. Accident

Date of accident / / DD/MM/YYYY

Time of accident : ☐ AM ☐ PM HH:MM

Place of accident – include name of nearest cross road or property number

Address

Suburb/Town | State | Postcode

What was your part in the accident (driver, passenger, cyclist, pedestrian, other)?

If your part required the use of a seatbelt or helmet, were you wearing one?

If you were in or on a vehicle, what was its registration number and state?

Reg. no. | State

Had you had any alcohol or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes Type ☐ No

Drugs: ☐ Yes Type ☐ No

Who caused the accident and why?

Describe what happened.

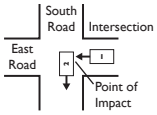
Draw a diagram to assist your description

Symbols: 1 vehicle that caused the accident

2 3 other vehicle(s)

Diagram must be manually drawn

Example Diagram



Vehicles in the accident (If more than 2 vehicles, please provide the details on the additional information page at the back of this form)

Vehicle 1 ***(Vehicle 1 is the one considered the "Most At Fault" vehicle)***

Registration number	State	Year of manufacture	Make (e.g. Ford)

Model (e.g. Laser)	Body type (e.g. Sedan)	Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know

Drugs: ☐ Yes ☐ No ☐ Don't know

Vehicle 2

Registration number	State	Year of manufacture	Make (e.g. Ford)

Model (e.g. Laser)	Body type (e.g. Sedan)	Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know

Drugs: ☐ Yes ☐ No ☐ Don't know

3. Witness

Did any person witness the accident?

☐ Yes ☐ No

If Yes, please advise the name, address and telephone number of each witness:

4. Police report

Did Police come to the scene of the accident?

☐ Yes ☐ No

If No, when was the accident reported to Police?

/ /

DD/MM/YYYY

Police accident report reference number

Police officer's name

Police station

5. Employment at Date of Accident

Have you lost or will you lose wages, salary, business or other income because of the accident? ☐ Yes ☐ No

Employed – name(s) and principal address(es) of employer(s)

Self-employed – name(s) and principal address(es) of business(es)

Full time, part time or casual or other (please describe)

☐ Full time ☐ Part time ☐ Casual

☐ Other:

Have you returned to work?

☐ Yes ▶ Date returned / /

DD/MM/YYYY

☐ No

Is there or will there be a Worker's Compensation or any other type of claim for the injury?

☐ Yes ☐ No

Yes: Name of insurer and claim number

If not employed or self-employed, what was the source of your income?

Weekly gross income

$

Average weekly gross income for last 12 months

$

6. Solicitor/Lawyer

Have you retained a solicitor/lawyer?

☐ Yes ☐ No

If Yes, date of first consultation

/ /

DD/MM/YYYY

If Yes, please advise name and address of legal firm.

Name		
Address		
Suburb/town	State	Postcode

7. Payment to You/Offer of Settlement

Are you in a position to accept payment for your claim? ☐ Yes ☐ No

If Yes, please provide the details of the nature and extent of your loss, and the amount that you would be willing to accept in full satisfaction of your claim. If No, please advise the reason

In any case, please attach all supporting documentary evidence, such as reports, accounts and receipts that you have.

8. Declaration and Authorisation

Protection of Privacy

- The information collected by this Notice of Accident Claim Form, and throughout the course of your claim, is collected in accordance with the *Motor Accident Insurance Act 1994 and Regulations*.
- The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to help the administration of the statutory insurance scheme and the detection of fraud.
- The information collected by this Notice of Accident Claim Form, and throughout the course of your claim, may be disclosed in accordance with the *Motor Accident Insurance Act 1994 and Regulations* to such bodies as the Motor Accident Insurance Commission, 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 the personal information held as provided by the *Privacy Act 1988 (C'th)*, or if the information is held by the Queensland Government you are able to gain access to the information as provided by the *Information Privacy Act 2009*.

Authority to obtain information

The injured person must complete all of the information required in this Notice of Accident Claim Form.

† This form must be signed by the injured person unless he/she is either under the age of 18 years or unable to complete it. In these cases it must be completed and signed by an agent of the injured person, such as a parent, guardian, relative or friend. The signing of this form constitutes the injured person's written permission to allow the insurer to obtain records or information that may affect his/her claim (including information on his/her pre-accident circumstances). Persons and entities from whom information may be obtained from or provided to include:

- other licensed insurers
- an insurer carrying on the business of providing CTP insurance, workers' compensation insurance, personal accident or illness insurance, or insurance against the loss of income through disability
- a department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws
- a hospital (including a private hospital)
- the ambulance service or other emergency service
- a doctor, professional provider of rehabilitation services or person professionally qualified to assess cognitive, functional or vocational capacity
- an employer (or previous employer)
- an educational institution
- the Office of the Director of Public Prosecutions
- the Legal Services Commission
- the Queensland Workers' Compensation Regulatory Authority

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

Under Section 87U of the *Motor Accident Insurance Act 1994* a person can be fined up to $15,000 or be imprisoned for up to one(1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information given in the Notice of Accident Claim Form must be true, correct and complete.

I hereby authorise the insurer against whom this claim is made or the claim manager to contact those persons and entities aforementioned and to obtain information and documents relevant to the claim.

I hereby authorise those persons or entities listed in this section, particularly doctors who have treated me for my injuries and hospitals where I have been treated for my injuries, to provide information and documents to the insurer or the claim manager against whom this claim is made.

I understand this declaration and authorisation and I declare that to the best of my knowledge and belief the statements of fact contained in this Notice of Accident Claim Form (including the attached pages) are true, correct and complete in every respect.

Signature of Injured Person | Date

/ / DD/MM/YYYY

Surname/family name | Given names

† Signature of Agent (if Injured Person unable to sign) | Date

/ / DD/MM/YYYY

Witness of signature

I am over the age of 18 years and certify that the injured person/agent signing this form is known to me by the stated name on this form and I have witnessed their signing of this form

Signature of Witness | Date | Place

/ / DD/MM/YYYY

Surname/family name of Witness | Given names of Witness

Address of Witness | Suburb/town | State | Postcode | Telephone

( )

† Agent of Injured Person
If another person signs on behalf of the Injured Person:

Surname/family name of Agent | Given names of Agent

Address of Agent | Suburb/town | State | Postcode | Telephone

( )

Relationship to the Injured Person | Reason why the Injured Person could not sign

Medical Certificate

For CTP Insurance Claims
to be completed by a Medical Practitioner

For information on the Qld Compulsory Third Party Scheme phone the CTP Helpline on 1300 302 568

Injured Person's information

Injured person's surname/family name

Given names

Date of birth / / DD/MM/YYYY

Medical information

Date of accident / / DD/MM/YYYY

Date of initial examination / / DD/MM/YYYY

Are the injuries/conditions consistent with the circumstances of the motor accident described to you? ☐ Yes ☐ No

Medical diagnosis or description of injury

Clinical findings (symptoms, results of any investigations, and details of treatment/rehabilitation to date)

Patient treated at hospital? ☐ Yes ☐ No

If admitted to hospital, was it longer than 24 hours? ☐ Yes ☐ No

Did patient require an ambulance? ☐ Yes ☐ No

Name of hospital

Proposed treatment plan

Treatment likely to be required: ☐ Nil ☐ Short term (<6 weeks) ☐ Medium term (6-12 weeks) ☐ Long term (>12 weeks)

Details of treatment plan (including recommendations and advice to patient)

Referred to:	Type	Name of person	Phone number or contact details
☐ Specialist			
☐ Therapy			
☐ Other			

Describe the patient's fitness for work

☐ Fit to resume normal duties on	/ /	
☐ Fit for alternative duties on	/ /	
☐ Unfit for work from	/ / DD/MM/YYYY	to / / DD/MM/YYYY

Date of next medical review / / DD/MM/YYYY

Medical Practitioner's information

Name (please print)

Provider number

Practice name and address/hospital name

Telephone number ( )

Professional qualification

I declare that I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Signature

Date / / DD/MM/YYYY

MAIC form 01-02 m.c

Additional Vehicles

Vehicle 3

Registration number	State	Year of manufacture	Make (e.g. Ford)

Model (e.g. Laser)	Body type (e.g. Sedan)	Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know	Drugs: ☐ Yes ☐ No ☐ Don't know

Vehicle 4

Registration number	State	Year of manufacture	Make (e.g. Ford)

Model (e.g. Laser)	Body type (e.g. Sedan)	Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know	Drugs: ☐ Yes ☐ No ☐ Don't know

Additional information/excuse for delay