Notice of Claim Form

This form is Approved Form AF2014-60, approved on 26 August 2014 by Karen Doran, delegate of the director-general, under section 276 of the *Road Transport (Third-Party Insurance) Act 2008*
As prescribed by section 84 of the *Road Transport (Third-Party Insurance) Act 2008*

Notice of Claim

Part A: Notice of intention to proceed with a claim under section 84

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr
☐ Other _____

Full name _____

Address _____

CTP insurer of the motor vehicle that caused the accident _____

CTP Claim number (if known) _____

Your intention to Proceed with this Claim

(As prescribed under Section 84(2)(a) of the Road Transport (Third-Party Insurance) Act 2008 and Part 6, section 20 of the Road Transport (Third-Party Insurance) Regulation 2008 (Regulation))

I, (please print in BLOCK LETTERS) ....., intend to proceed with this claim against the Respondent in anticipation that all matters under Part 4.2 of the *Road Transport (Third-Party Insurance)* Act 2008 have been fully complied with.

Protection of Privacy

- The information collected by this Notice of Claim Form, and throughout the course of your claim, is collected in accordance with the *Road Transport (Third-Party Insurance)* Act 2008 (the Act) and Road Transport (Third-Party Insurance) Regulation 2008 (the Regulation).
- The information is collected, held, used and disclosed so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to assist the CTP regulator with the administration of the statutory insurance scheme including the detection of fraud and conducting research. This may include the CTP regulator contacting you to discuss your claim experience.
- The information collected by this Notice of Claim Form and throughout the course of your claim, may be disclosed in accordance with the Act and the Regulation to such bodies as, the CTP regulator, 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 personal information held as provided by the Privacy Act 1988 (Cth), or if the information is held by the Australian Capital Territory Government, you are able to gain access to the information as provided by the road transport legislation
- Any personal information you provide to the CTP Insurer will be collected, held, used and disclosed in accordance with their Privacy Policy. You will be able to view their privacy policy on their website or you can request that the Insurer send you a copy.

Your Signature _____ Date _____

Your full name _____

Part B: Additional Information

(If you have not already completed a Motor Accident Notification Form in relation to this accident please complete and submit one along with this form and return to the insurer)

Section 1: Employment Details

Employment status at the time of the accident

- ☐ Full Time Employed
- ☐ Casual
- ☐ Self-Employed
- ☐ Part Time Employed
- ☐ Retired
- ☐ Home Duties
- ☐ Student/Child
- ☐ Not Working
- ☐ Pension
- ☐ Other

If pension or other please describe:

Occupation/Job Type

Name of Employer

Contact Person

Phone Number

Address

Description of work duties

Earnings prior to the accident

Usual Weekly Working Hours

Ordinary Hours

Overtime Hours (if applicable)

Average Weekly Earnings prior to the accident (including overtime, regular bonuses and commissions)

Gross earnings (before tax)

Net earnings (after tax)

Lost earnings / Return to Work

Have you lost any income as a result of this accident?

- ☐ Yes
- ☐ No

Have you returned to work?

- ☐ Yes
- ☐ No

Date returned to work

Date expected to return to work:

Is the work or your weekly earnings different because of the accident?

- ☐ Yes
- ☐ No

If yes, please provide details

Self-Employed Claimants ONLY

Have you lost any income as a result of this accident? ☐ Yes ☐ No

If yes, please provide details

Details of replacement labour

Name of Business

ABN Number

Nature of Business

Accountant's Name

Accountant's Address

Phone Number

Section 2: Witnesses

Witness 1

Full Name

Street Address

Phone Number

Alternate Phone Number

Witness 2

Full Name

Street Address

Phone Number

Alternate Phone Number

Please attach a list with these details if there are more than two witnesses

Section 3: Further Accident Details

Were you wearing a seatbelt? ☐ Yes ☐ No ☐ Not Applicable

Were you wearing a helmet? ☐ Yes ☐ No ☐ Not Applicable

Had you consumed any prescription medication, alcohol or drugs in the last 12 hours before the accident? ☐ Yes ☐ No

If you were the passenger, had the driver consumed any prescription medication, alcohol or drugs in the last 12 hours before the accident? ☐ Yes ☐ No ☐ Unknown

Did anyone or anything other than the driver cause or contribute to the accident? ☐ Yes ☐ No

If yes, please provide details

Section 4: Legal Representation

Do you have a solicitor acting for your claim? ☐ Yes ☐ No

Name of Firm

Name of Solicitor

Date you instructed a solicitor

Date you first identified relevant insurer

Under Section 116 of the *Road Transport (Third-Party Insurance) Act 2008* a person can be fined up to $15,000 and/or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. A person can also be fined up to $7,500 and/or imprisoned for up to six (6) months if they are reckless about providing false, misleading or incomplete particulars in the form. Therefore, all information given in this Notice of Claim Form must be true, correct and complete.

Declaration

I confirm that the information provided in this form is true and correct to the best of my knowledge

Signature of claimant

Date

Print full name

Signature of witness

Date

Print full name

This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant is unable to sign, this form must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf of the claimant). Please provide details of the person who signs as agent of the claimant below (Agent of the claimant).

Agent's Full Name

Phone Number

Alternate Phone Number

Relationship to Claimant

Reason(s) why the Claimant could not sign