

**INCOME CLAIM FORM  
FOR NON-WORK  
RELATED INJURY OR SICKNESS**  
(Medical/Surgical or Specialist costs are not covered)

This INCOME CLAIM FORM FOR NON-WORK RELATED INJURY OR ILLNESS is to be returned to All Trades Queensland:

Fax to: (07) 3806 1125  
Post to: All Trades Queensland PO Box 3653 Loganholme QLD 4129  
Email to: admin@atq.com.au  
In person to: 37-43 Commercial Drive Shailer Park or  
Unit 7/1015 Nudgee Road Banyo

| INSTRUCTIONS |  |
|--------------|--|
| 1:           | <b>YOU <u>must</u></b> read these instructions carefully and complete your personal details listed at the bottom of this page  |
| 2:           | <b>YOU <u>must</u></b> complete either:<br><u>Section A</u> - Injury Statement <b>OR</b> <u>Section B</u> - Sickness Statement<br><b>AND</b> Claimant declaration – <u>Section C</u>                     |
| 3:           | <b>YOUR</b> family/regular doctor <u>must</u> complete Medical Practitioner's Statement – <u>Section D</u>   |
| 4:           | <b><u>ALL</u></b> Medical certificates <u>must</u> be attached at time of application  |
| 5:           | Relevant sections <u>must</u> be completed quickly and entirely for due process as any delays can cause commencement of payments to be prolonged   |
| 6:           | <b><u>ALL</u></b> further medical certificates issued in relation to this claim must be forwarded immediately to All Trades Queensland Head Office at Shailer Park to allow for continuation of payments |

OPTIONAL: Call Centrelink on 13 27 17 to register an 'Intent to claim for Sickness Allowance' – in case your claim is not accepted as Centrelink take 21 days to process. .

**BEFORE YOU RETURN TO WORK:** you must fax / send /email or deliver your medical certificate to All Trades Queensland from your GP or treating specialist that states you are fit to return to FULL DUTIES

**Claimants details**

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Phone number: \_\_\_\_\_

Any benefits paid in relation to this claim will be paid into your payroll bank account.

THIS CLAIM FORM COVERS INJURIES AND SICKNESS LISTED IN THE COLLECTIVE AGREEMENT (UCA)

**Injury Statement – Section A**

*Complete if your claim is a result of an injury*

Date of Injury: \_\_\_/\_\_\_/\_\_\_ Time of Injury: \_\_\_\_\_ am/pm

**Q1** What is the nature of the injury? Sprain, Fracture, degenerative etc: \_\_\_\_\_

**Q2** What part (s) of the body does this relate to? Leg, arm, back etc: \_\_\_\_\_

**Q3** In detail, how did the injury occur? \_\_\_\_\_

**Q4** In detail, what address and location did the injury occur? \_\_\_\_\_

**Q5** Is the injury sports related? No  Yes  If yes, what is the name of your sporting club? \_\_\_\_\_

If yes, do you get paid by your club for playing this sport? No  Yes

**Q6** Were there any witnesses? No  Yes  (please give details) \_\_\_\_\_

**Q7** Have you previously suffered any similar injuries or conditions? No  Yes  (please give details)

**Q8** Had you consumed any alcohol, drugs or prescription medication 8 hours prior to the accident? No  Yes  (please give details)

**Q9** In the table below please list all your treating doctors over the past five years:

| Doctors Name | Consultations |    | Specialty | Phone | Fax |
|--------------|---------------|----|-----------|-------|-----|
|              | From          | To |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |

**Q10** When did you first seek medical attention as a result of the injury? \_\_\_\_\_

**Q11** What is the name of your treating doctor/ specialist and the clinic address? \_\_\_\_\_

**Q12** Have you ever lodged a personal injury claim before? No  Yes  (please give details) \_\_\_\_\_

**Sickness Statement – Section B**

*Please only complete this section if your claim is for sickness*

**Q1** What sickness/ illness are you suffering from resulting in you claiming Income Protection? \_\_\_\_\_  
\_\_\_\_\_

**Q2** What date did you first become aware of this condition? \_\_\_/\_\_\_/\_\_\_

**Q3** What date did you first seek treatment from a doctor in relation to this condition? \_\_\_/\_\_\_/\_\_\_

**Q4** What date were you first unable to attend your usual duties as a result of this condition? \_\_\_/\_\_\_/\_\_\_

**Q5** Have you ever had a similar condition in the past? If so please specify the dates you were being treated for this condition:

| Doctors Name | Consultations |    | Specialty | Phone | Fax |
|--------------|---------------|----|-----------|-------|-----|
|              | From          | To |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |

**Q6** Please list all your treating medical practitioners over the past five years:

| Doctors Name | Consultations |    | Specialty | Phone | Fax |
|--------------|---------------|----|-----------|-------|-----|
|              | From          | To |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |
|              |               |    |           |       |     |

**Q7** At any time have your treating doctors advised you to cease treatment for this sickness/illness? No  Yes

## **Claimant declaration – Section C**

As a result of your injury/ illness are you planning on lodging a claim with any of the insurers listed below?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Motor Accident compensation Benefit           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Centre link or Government Disability Benefits | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Sports Insurance with a club                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Superannuation Life Insurance                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Private Health Insurance                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Any other party for any benefits              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered yes to any of the above please give details:

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Important notice: You should be aware that in making a claim under All Trades Queensland Income Protection you will forego any long-term benefits and rights under Workers Compensation entitlements.

The National Privacy Policy instructs that this organisation must take reasonable steps to protect the personal information it holds from misuse and loss and from unauthorised access, modification or disclosure.

In order to process and manage a claim for income protection All Trades Queensland or its representative Blue Broking Pty. Ltd will need to obtain personal information about an individual's health and medical history, criminal records and any membership to sporting clubs etc.

You have given All Trades Queensland or its representative Blue Broking Pty. Ltd your consent to collect your personal and sensitive information in order to issue you with this coverage.

All Trades Queensland or its representative Blue Broking Pty. Ltd disclose personal information to third parties who they deal with in providing the relevant services and products. For example in handling claims, we may have to disclose your personal information to third parties such as insurers, reinsurers, external claims data collectors, investigators and agents of other parties as required by law. We limit the use and disclosure of any personal information provided by All Trades Queensland or its representative Blue Broking Pty. Ltd to them to the specific purpose for which we supplied it.

You have the right to seek access to your personal information and sensitive information and to correct it at any time.

### **Medical Authority**

I authorise any Hospital, Doctor or Medical Physician who I have received treatment from or been examined by to furnish All Trades Queensland or its representative Blue Broking Pty. Ltd with any and all information they require to assist in the assessment and settlement of this claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

### **Declaration:**

I solemnly and sincerely declare that the information given in this form is truthful accurate and complete. No information likely to affect this claim has been withheld.

I understand that this claim may be refused if information is untrue, inaccurate or concealed.

I acknowledge that I have read and understood the National Privacy Policy and Medical Authority above and consent to the collection, storage, use and disclosure of my personal and sensitive information.

I acknowledge that if I don't agree to the collection of this personal and sensitive information All Trades Queensland or its representative Blue Broking Pty. Ltd will be unable to process this claim.

Claimant Signature \_\_\_\_\_ Print name \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Declared before me \_\_\_\_\_, at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_  
(Justice of the Peace/Commissioner for Declarations)

**Medical Practitioners Statement – Section D**

*“The Patient will be responsible for any fee charged to complete this section”*

Patients Name: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_

**Q1** Onset of illness or injury date, if known? \_\_\_\_\_

**Q2** What date did the patient first consult you regarding this condition? \_\_\_\_\_

**Q3** Are you the first legally qualified medical practitioner that this patient has seen in relation to this condition?  
No  Yes  (please give details) \_\_\_\_\_

**Q4** How long has the patient been attending your practice? \_\_\_\_\_

**Q5** In your opinion what is the patient’s injury/ sickness? \_\_\_\_\_

**Q6** What do you believe to be the cause of this injury/ sickness? \_\_\_\_\_

**Q7** Has the patient suffered from the same or similar condition before? No  Yes  (please give details) \_\_\_\_\_

**Q8** Are there any conditions impacting on the patients disablement No  Yes  (please give details) \_\_\_\_\_

**Q9** In your opinion did the patient sustain an injury in the workplace or aggravated a pre-existing condition causing the patients’ current disablement? No  Yes  (please give details) \_\_\_\_\_

**Q10** In your opinion, is this condition relating to a motor accident compensation claim No  Yes

**Q11** Was the patient participating in any sport at the time of his/ her accident No  Yes  (please give details) \_\_\_\_\_

**Q12** Is there any medical evidence that drugs, alcohol or prescription medication has contributed to the injury/ illness?  
No  Yes  (please give details) \_\_\_\_\_

**Q13** Please provide any relevant medical history that may assist us with this claim: \_\_\_\_\_

**Q14** Does the patient have a current treatment program if so please give details? \_\_\_\_\_

**Q15** Have you at any time advised the patient to stop treatment? No  Yes  If yes, what date did you advise? \_\_\_/\_\_\_/\_\_\_

**Q16** Has the patient been hospitalised? No  Yes  Name of hospital \_\_\_\_\_

Period of hospitalisation \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**Q17** How long will or was the patient totally disabled? (unable to perform any part of their occupation)

Totally disabled from: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ (both dates are inclusive)

**Q18** How long will or was the patient partially disabled? (unable to perform some part of their occupation)

Partially disabled From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ (both dates are inclusive)

**Q19** Does the patient need a further review? No  Yes  if yes, what date? (if known) \_\_\_/\_\_\_/\_\_\_

**Q20** Is your patient able to undertake theory in a classroom at college? No  Yes

**Q21** Please provide details of your patient's abilities/restriction in the table below

| Activity                   | Able to perform<br>(please circle) | Capacity<br>(Hrs/Mins/Weight) | Breaks required every<br>(Hrs/Mins) |
|----------------------------|------------------------------------|-------------------------------|-------------------------------------|
| Standing                   | Yes/No                             |                               |                                     |
| Walking                    | Yes/No                             |                               |                                     |
| Climbing/descending stairs | Yes/No                             |                               |                                     |
| Crawling                   | Yes/No                             |                               |                                     |
| Squatting                  | Yes/No                             |                               |                                     |
| Bending                    | Yes/No                             |                               |                                     |
| Kneeling                   | Yes/No                             |                               |                                     |
| Sitting                    | Yes/No                             |                               |                                     |
| Repetitive movements       | Yes/No                             |                               |                                     |
| Operate machinery          | Yes/No                             |                               |                                     |
| Lifting (weight)           | Yes/No                             |                               |                                     |
| Lifting (at height)        | Yes/No                             |                               |                                     |
| Overhead work              | Yes/No                             |                               |                                     |
| Travelling                 | Yes/No                             |                               |                                     |
| Driving                    | Yes/No                             |                               |                                     |
| Other _____                | Yes/No                             |                               |                                     |

**Please enclose any results, analysis reports or BAC readings in relation to the claimant's condition.**

Name: \_\_\_\_\_ Qualification: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Post code: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Affix Stamp Here

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