

MOTOR ACCIDENT PERSONAL INJURY CLAIM FORM



**MOTOR ACCIDENTS
AUTHORITY**

THIS CLAIM FORM IS APPROVED BY THE MOTOR ACCIDENTS AUTHORITY OF NSW. IT IS TO BE USED FOR CLAIMS MADE UNDER THE MOTOR ACCIDENTS COMPENSATION ACT 1999 AFTER 1 OCTOBER 2007

Who Can Make a Claim

If you were injured in a motor vehicle accident in NSW, there are a number of circumstances under which you may be eligible to make a claim for personal injury compensation.

1. Other driver or owner of vehicle at fault

Whether you were a driver, passenger, pedestrian, cyclist, motorbike rider or pillion passenger you can make a claim for personal injury compensation if you can demonstrate a driver or owner of a motor vehicle, other than you, was partially or completely at fault. If you were partly at fault, (e.g. not wearing a seatbelt) you may still be able to make a claim.

2. Special benefit for children in accidents from 1 October 2006

You may make a claim for the children's special benefit even if the accident was not caused by the fault of an owner or driver of a motor vehicle (i.e. the accident was caused by the child), provided that:

- the accident happened on or after 1 October 2006
- you were under 16 years at the time of the accident
- you lived in NSW at the time of the accident.

Please refer to the Important note for injured children on page 6 for more information.

3. Blameless accidents from 1 October 2007

If you are injured in an accident on or after 1 October 2007, you may be able to make a claim for personal injury compensation even if the accident was a blameless motor accident. A blameless accident is a motor accident in which the driver or owner of a motor vehicle was not at fault. Examples of blameless motor accidents could include accidents resulting from the sudden illness of a driver, such as a heart attack or stroke or vehicle failure, such as a tyre blow-out.

You can make a claim if you were a passenger, pedestrian, cyclist, pillion passenger, driver or motorcycle rider. However, special rules apply to drivers and motorcycle riders in blameless accidents. You may not be entitled to make a claim if you were injured in a single vehicle accident or if you were driving or riding the vehicle that caused the accident (i.e. you were the driver that suffered a medical condition which resulted in the motor accident).

For more information about the special rules that apply to drivers and motorcycle riders in blameless accidents, contact the Claims Advisory Service on 1300 656 919.

If you have already completed an Accident Notification Form (ANF) you will still need to complete the Motor Accidents Personal Injury claim form if you want to make a claim for treatment expenses in excess of \$500 or claim for other types of compensation.

Where To Send The Claim Form

You must send the completed claim form to the green slip or Compulsory Third Party (CTP) insurer of the motor vehicle you consider caused the accident. If you are unsure of where to send your claim form contact the MAA's Claims Advisory Service on 1300 656 919.

The claim form must be sent to the CTP insurer as soon as possible but no later than six months from the date of the accident. You can still make a claim more than six months after the accident. However, your claim could be rejected if the insurer receives your claim more than six months after the accident and you cannot give a satisfactory reason for the delay.

Need More Information?

- Contact the Claims Advisory Service on 1300 656 919, or
- Visit the Motor Accidents Authority's (MAA) website at www.maa.nsw.gov.au.

ABOUT THE INFORMATION IN THIS FORM

The information in this form is required by law

The information in this form is required by laws covering motor accidents compensation. Failure to provide the required information may result in delays in processing your claim or it being rejected.

The information in this form is used by insurers to help determine liability for your claim and your compensation entitlements. It is important that you answer the questions fully. For example, you should list all injuries that were caused in the accident.

Your information is confidential

The information in this form will be treated confidentially. Only staff of the Motor Accidents Authority (MAA), CTP insurers and other approved bodies with proper legal authority are allowed to access your information and are restricted in how they use the information. You have the right to access and correct information about you held by the MAA or CTP insurers if you consider:

- that your personal information has been handled incorrectly by the MAA, you can ask the authority to undertake an internal review or you may contact Privacy NSW.
- an insurer has handled your information incorrectly, you may contact the relevant insurer for an internal review or the Office of the Federal Privacy Commissioner.

CTP insurers are bound by national privacy principles. You may visit the licensed insurers' websites or contact them directly to request information on how to access your personal information, seek an internal review or determine with whom they share the information.

The information you provide must be truthful

You must answer the questions fully and truthfully. Information that is knowingly false or misleading may result in a fine of up to \$5,500 or imprisonment for up to 12 months or both.

INTERPRETER ASSISTANCE

If you need an interpreter service to help you read this form, contact:

Associated Translators & Linguists Pty Ltd

Level 5, 72 Pitt Street, Sydney, NSW 2000

P: 02 9231 3288 F: 02 9221 4763 www.atl.com.au

Office hours: 8.00 am to 5.30 pm (this interpreter service is provided free of charge to claimants).

ARABIC	.9231 3288 رقم بتليفون الإتصال بالطلب. فالرجاء لقراءة هذا المترجم الى مترجم لقراءة هذا المترجم
CHINESE	如您需要傳譯員讀這表格請致電 9231 3288 如您需要传译员读这表格请致电 9231 3288
CROATIAN	AKO TREBATE PREVODITELJA DA VAM PROČITA OVAJ FORMULAR NAZOVITE 9231 3288
FARSI	.اگر برای خواندن این فرم به مترجم احتیاج دارید به شماره 9231 3288 تلفن کنید.
GREEK	AN XREIAZEΣTE ΔΙΕΡΜΗΝΕΑ ΝΑ ΣΑΣ ΔΙΑΒΑΣΕΙ ΑΥΤΟ ΤΟ ΕΝΤΥΠΟ ΤΗΛΕΦΩΝΗΣΤΕ ΣΤΟ 9231 3288.
INDONESIAN	JIKA ANDA MEMERLUKAN BANTUAN PENERJEMAH UNTUK MEMBACA FORMULIR INI, SILAHKAN MENELEPON 9231 3288.
ITALIAN	SE AVETE BISOGNO DI UN INTERPRETE PER LEGGERE QUESTO MODULO CHIAMATE IL 9231 3288.
KOREAN	이 서식을 읽기 위해 통역이 필요하시면 전화 9231 3288로 연락 주십시오.
MACEDONIAN	AKO VI TREBA TOLKUVACH DA VI GO PROČITA OVOJ FORMULAR JAVETE SE NA 9231 3288.
POLISH	JEŚLI DO PRZECZYTANIA TEGO FORMULARZA POTRZEBUJE PAN(I) POMOCY TŁUMACZA, PROSZĘ ZATELEFONOWAĆ POD NUMER 9231 3288
PORTUGUESE	SE NECESSITAR QUE UM INTÉRPRETE LHE LEIA ESTE IMPRESSO TELEFONE PARA O NÚMERO 9231 3288.
SERBIAN	AKO TREBATE PREVOĐIJOCA DA VAM PROČITA OVAJ FORMULAR NAZOVITE 9231 3288.
SPANISH	SI NECESITA QUE UN INTERPRETE LE LEA ESTE DOCUMENTO, LLAME AL: 9231 3288.
TAGALOG (FILIPINO)	KUNG KAILANGAN NINYO NG TAGASALINWIK (INTERPRETER) SA PAGBABASA NG NAKASULAT DITO TUMAWAG SA 9231 3288
TURKISH	BU FORMU OKUMAK İÇİN TERCÜMANA İHTİYACINIZ VARSA 9231 3288. 'E TELEFON EDİNİZ.
VIETNAMESE	NẾU BẠN CẦN THÔNG DỊCH VIÊN ĐỂ ĐỌC MẪU ĐƠN NÀY HÃY GỌI ĐIỆN THOẠI SỐ 9231 3288.

If you need an interpreter to help you read this form, the declaration below must be completed by the interpreter and the injured person.

Interpreter declaration

- 1 We declare that the Motor Accident Personal Injury Claim Form has been read to the undersigned injured person by the undersigned interpreter.
- 2 We understand that the Motor Accidents Authority of New South Wales and Associated Translators & Linguists Pty Limited bear no responsibility for any loss whatsoever arising from the interpreting service provided.
- 3 We acknowledge that the interpreting service provided by Associated Translators & Linguists Pty Limited was limited to reading the claim form.
- 4 This declaration has been read to the injured person by the undersigned interpreter.

Injured person's name

Injured person's signature

Interpreter's name

Interpreter's signature

Injured person's address

Date:

MAKING A CLAIM FOR PERSONAL INJURY COMPENSATION

There are a number of steps to making a claim:

1 Report the accident to the police

You must report the accident to the police as soon as possible, and in any case, within 28 days after the accident. If you make a late report to the police and cannot give a reason, it could affect the insurer's decision about your claim. If you make a late report to the police, please attach an explanation to this claim form giving the reasons for the delay.

2 Find out the CTP insurer of the NSW motor vehicle you consider caused the accident

Contact the Claims Advisory Service on 1300 656 919 to find out the CTP insurer. You will need to give them the NSW registration number plate of the motor vehicle you consider caused the accident and the date of the accident. If the motor vehicle you consider caused the accident is:

- not a NSW registered motor vehicle, you will need to contact the relevant state or territory.
- unregistered or cannot be identified (e.g. hit and run) see step 4 below for further instructions.

3 The motor vehicle and person you consider caused the accident

You must indicate the motor vehicle and/or person you consider caused the accident (Q20). If you are having difficulty in finding out the motor vehicle registration number and/or the person you consider caused the accident contact the police.

4 The motor vehicle you consider caused the accident was uninsured or unidentified

The Nominal Defendant receives claims where the motor vehicle you consider caused the accident cannot be identified or is uninsured, and the accident occurred in NSW.

Before sending the claim you must take action to find out the registration number of the motor vehicle or the person you consider caused the accident. For example, by putting an advertisement in the newspaper or attempting to talk to witnesses.

If you cannot find out the registration number or if the motor vehicle is unregistered and not covered by CTP insurance, send your claim to the Nominal Defendant at Level 25, 580 George Street, Sydney, NSW 2000, (DX 1517 Sydney). If you need more information about the Nominal Defendant call 1300 137 131 or visit www.maa.nsw.gov.au

5 Medical certificate

Your claim may be considered incomplete and may be delayed or rejected if the medical certificate at the back of this claim form is not sent to the CTP insurer with your Personal Injury Claim Form.

6 Send the claim form and the medical certificate to the CTP insurer

You must send the completed claim form and medical certificate to the CTP insurer of the motor vehicle you consider caused the accident (see step 2 above).

The claim form and the medical certificate must be sent as soon as possible, but no later than six months from the date of the accident. You can still make a claim more than six months after the accident. However, your claim could be rejected if the insurer gets your claim more than six months after the accident and you cannot give a satisfactory reason for the delay. If you make a claim more than six months after the date of the accident, please attach an explanation to this claim form giving the reasons for the delay.

7 If you were under 16 years at the date of accident

Attach proof of age (a certified copy of your birth certificate or passport). If you wish to claim the children's special benefit you should also attach proof that you were a resident of NSW at the date of accident. (Refer to the important note for injured children on page 6).

8 Keep a copy of the completed forms and accounts and invoices

Please attach any original accounts and invoices you may already have to the claim form. Keep a copy of all forms, certificates, accounts and invoices, etc, so that you have your own record.

AFTER YOU SEND YOUR CLAIM TO THE CTP INSURER

1 You will receive a letter from the insurer

The insurer will write to you within five working days of receiving your claim. The letter should also include a claim or reference number. If you have not heard from the insurer within two weeks of sending your claim, please contact the insurer.

2 You must help the CTP insurer with its investigation of your claim

You may be required to give the CTP insurer more information, photographs, documents or records. You may have to attend a medical examination organised by the insurer.

You must take all reasonable steps to recover from your injury, including undertaking all reasonable and appropriate treatment and rehabilitation. You must try to reduce your lost income, for example, by seeking alternative work, subject to your injuries and medical advice.

3 The insurer will tell you its decision about your claim

The insurer will tell you whether liability is accepted (fully or partly) or denied. The insurer is required to make a decision on liability within three months of a claim being made. If liability is accepted the insurer is obliged to pay reasonable and necessary:

- hospital, medical, rehabilitation, pharmaceutical, respite care and attendant care expenses, and
- travel and accommodation expenses associated with your receiving rehabilitation services.

After accepting liability, the insurer is only required to pay these expenses when they:

- are reasonable and necessary,
- are properly verified (original receipts, accounts or invoices) and,
- relate to the injury caused by the owner or driver of the motor vehicle.

If the CTP insurer denies liability on your claim, contact the Claims Advisory Service on 1300 656 919 for further information as you may have further rights against the CTP insurer.

4 Important note for injured children

From 1 October 2006, a special benefit will be available to children living in NSW who were under 16 at the time they were injured in the accident. The special benefit may be claimed when the accident was not caused by the driver or owner of a motor vehicle and provides for hospital, medical, rehabilitation, pharmaceutical, respite care and attendant care expenses. If the accident was caused, wholly or in part, by the driver or owner of a motor vehicle other compensation entitlements may apply.

5 Once your injuries have become stable and treatment is completed

You may negotiate with the insurer and settle the claim yourself. That settlement would represent a full and final resolution of your claim.

If you have a dispute about any part of your claim, you can contact the insurer, who has an internal complaints and dispute handling system. You can discuss any part of your claim with the insurer or you may seek legal advice.

6 CTP Insurer handling of your claim

CTP insurers are required to comply with the MAA Claims Handling Guidelines, which are available at www.maa.nsw.gov.au. If you need a copy sent to you, contact the Claims Advisory Service on 1300 656 919.

PERSONAL DETAILS

Ms Mrs Miss
Mr Other Surname/family name
 Given name(s)

Have you ever been known by another name?

No Yes
 Surname/family name
 Given name(s)

Marital status: Never married Married (legal or defacto) Divorced Separated Widowed

Sex: M F Date of birth / /
Were you under 16 years at the date of the accident? No Yes

Driver's licence number Occupation

Medicare number State

Home address

Town/suburb State Postcode

Postal address (or as above)

Postbox Town/suburb State Postcode

Phone numbers
() Home
() Work
() Mobile

Email address

Do you need an interpreter to help you with your claim? No Yes
Language

Accident details

If you have not reported the accident to the police, report it immediately.

1 Have you previously completed an Accident Notification Form (ANF)?
No Yes
CTP insurer and reference or claim number

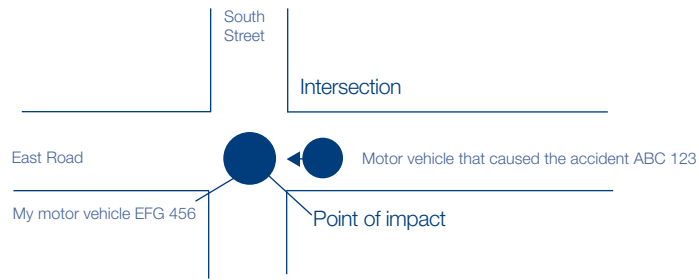
2 Date of accident / /
Time of accident : am/pm
Weather and road conditions

3 Place of the accident (streets and town or suburb)

Street(s) Town/suburb State Postcode

15 Draw a diagram of the accident. Include intersections, streets, roads and their names. Show the point of impact and position of all motor vehicles.

Example diagram for motor vehicle



Example diagram for pedestrian/cyclist

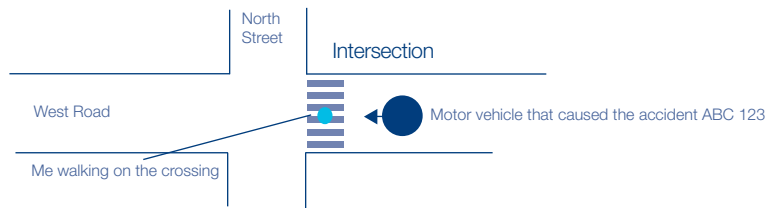


Diagram of the accident

Blank area for drawing the accident diagram.

16 Description of the accident (including who you consider caused the accident and how the accident happened)

Blank area for describing the accident, with horizontal lines for writing.

Please attach a separate page if you need to include more information.

DETAILS OF ALL MOTOR VEHICLES INVOLVED IN THE ACCIDENT

17 How many motor vehicles were involved in the accident?

18 Do you know the registration number of the motor vehicle you consider caused the accident?

Yes Go to Q20 No ► If you don't know this information after contacting the police go to Q19.

19 Applies to unidentified motor vehicles only

As the injured person, you have an obligation to provide evidence of steps taken to find out the registration number or the name of the person who drove the motor vehicle you consider caused the accident. Please list any actions you have taken and attach any proof such as a newspaper advertisement or account of discussions with any witnesses, etc. Fill in as many of the details at Q20 as you can.

Now fill in as many of the details in Q20 as you can

20 Provide details of the motor vehicle you consider caused the accident

Registration number

State

Make or model (e.g. Toyota Camry)

Type (e.g. station wagon, sedan)

Year of manufacture

Colour

Number of people in vehicle

Driver's licence number

State

Briefly describe the damage caused to this vehicle (if known)

Name of property damage or comprehensive insurer, if known

Driver's surname/family name

Driver's given name(s)

Driver's home phone

Driver's work phone

Driver's mobile phone

Driver's address

Town/suburb

State

Postcode

Owner's surname/family name (if same as driver, write "as above")

Owner's given name(s)

(Or organisation/company name)

Owner's home phone

Owner's work phone

Owner's mobile phone

Owner's address

Town/suburb

State

Postcode

21 Were you travelling in this vehicle? Yes Go to Q23 No

22 Provide details of the vehicle you were travelling in (if you were travelling in a vehicle)

Registration number	Make or model (e.g. Toyota Camry)	Type (e.g. station wagon, sedan)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
	State			
Year of manufacture	Colour	Number of people in vehicle	Driver's licence number	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Including driver		State
Briefly describe the damage caused to this vehicle (if known)	Name of property damage or comprehensive insurer, if known			
<input type="text"/>	<input type="text"/>			
Driver's surname/family name	Driver's given name(s)			
<input type="text"/>	<input type="text"/>			
Driver's home phone	Driver's work phone	Driver's mobile phone		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Driver's address				
<input type="text"/>				
	Town/suburb	State	Postcode	

23 Provide details of any other vehicle(s) involved in the accident

Registration number	Make or model (e.g. Toyota Camry)	Type (e.g. station wagon, sedan)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
	State			
Year of manufacture	Colour	Number of people in vehicle	Driver's licence number	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Including driver		State
Briefly describe the damage caused to this vehicle (if known)	Name of property damage or comprehensive insurer, if known			
<input type="text"/>	<input type="text"/>			
Driver's surname/family name	Driver's given name(s)			
<input type="text"/>	<input type="text"/>			
Driver's home phone	Driver's work phone	Driver's mobile phone		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Driver's address				
<input type="text"/>				
	Town/suburb	State	Postcode	

Please attach a separate page if you need to include more information.

DETAILS OF WITNESSES

24 Witnesses. Provide details of witnesses (including witnesses in the same motor vehicle as you).

Witness 1

Surname/family name

Given name(s)

Home address

Home phone

Work phone

Town/suburb

Mobile phone

State

Postcode

Registration number (if the witness was in a vehicle)

Relationship to injured person (if any)

State

Witness 2

Surname/family name

Given name(s)

Home address

Home phone

Work phone

Town/suburb

Mobile phone

State

Postcode

Registration number (if the witness was in a vehicle)

Relationship to injured person (if any)

State

Witness 3

Surname/family name

Given name(s)

Home address

Home phone

Work phone

Town/suburb

Mobile phone

State

Postcode

Registration number (if the witness was in a vehicle)

Relationship to injured person (if any)

State

Witness 4

Surname/family name

Given name(s)

Home address

Home phone

Work phone

Town/suburb

Mobile phone

State

Postcode

Registration number (if the witness was in a vehicle)

Relationship to injured person (if any)

State

Please attach a separate page if you need to include more information.

INJURY DETAILS

25 What are your injuries from the accident? (List all injuries and affected areas of the body, e.g. fracture to left leg and neck strain)

26 How do the injuries affect you now? (The effect of your injuries may change over time, e.g. have to use crutches and wear neck brace)

Please attach a separate page if you need to include more information.

27 Did you need an ambulance? Yes No

28 Did you go to a hospital after the accident?

No Go to Q32 Yes / /
Which hospital(s)? Date

29 Were you treated at the hospital? No Yes Date treated / /

30 Were you admitted to the hospital? No Go to Q32 Yes Date admitted / /

31 Have you been discharged from hospital? No Yes Date discharged / /

32 Who has treated you for your injuries since the accident?
 (List all doctors, surgeons, physiotherapists, specialists, etc)

Name	Specialty	Contact details	Is treatment ongoing? (Yes/No)

Please attach a separate page if you need to include more information

33 Are you aware of any treatment or rehabilitation plan(s) that has been developed for you?

No Go to Q34 Yes Describe below

Details of treatment or rehabilitation plan

34 Have you had any other injuries, disability or illness, before or since the accident, to the same part(s) of your body?

No Go to Q35 Yes Please complete the following information

Date (or approximately)	Injury or illness
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

Treatment	Doctor's name
<input type="text"/>	<input type="text"/>

Address (practice or surgery)

	Town/suburb	State	Postcode
Date (or approximately)	Injury or illness		
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>		

Treatment	Doctor's name
<input type="text"/>	<input type="text"/>

Address (practice or surgery)

	Town/suburb	State	Postcode
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35 Have you ever made a claim for personal injury compensation, workers compensation or other damages? (e.g. slip and fall, assault, medical negligence, or another motor accident)

No Go to Q36 Yes Please give details (if exact details are not known, please provide as much information as you can)

Date of injury	Insurance company	Claim or reference number	Type of claim
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of injury	Insurance company	Claim or reference number	Type of claim
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of injury	Insurance company	Claim or reference number	Type of claim
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please attach a separate page if you need to include more information.

EMPLOYMENT DETAILS (RELATING TO LOSS OF INCOME)

36 What was your employment situation before the accident?

- Self employed – go to Q44
 Full time employed
 Part time employed
 Retired
 Casual
 Student/child
 Home duties
 Not working
 Other
 Pensioner

Please describe

Please describe

37 Have you lost income because of the accident?

No Go to Q47 Yes

38 Are you still losing income?

No Yes

39 Is the work you do or are your weekly earnings different because of the accident ?

No Go to Q40 Yes Give details below

40 How many separate periods of time have you been away from work because of the accident? (Include short periods when you went for treatment or rehabilitation)

Work time lost (weeks/days/hours)	From	To
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

41 Have you returned to work?

Yes Go to Q42 No When do you expect to return to work ? / / Don't know

42 Employment details

Name of employer Contact person's name Contact phone number

Workplace address

Town/suburb

State

Postcode

Usual weekly working hours

Usual weekly earnings (including overtime, regular bonuses and commission)

Ordinary

Overtime

Pay before tax

Pay after tax

Description of duties

43 Did you have a second job before the accident?

No Go to Q47 Yes Give details

Name of employer Contact person's name Contact phone number

Workplace address

Town/suburb

State

Postcode

Usual weekly working hours

Usual weekly earnings (including overtime, regular bonuses and commission)

Ordinary

Overtime

Pay before tax

Pay after tax

Description of duties

Please attach a separate page if you need to include more information.

44 Have you lost income from self-employment in your business because of the accident?

No Go to Q46 Yes Give details

Name of business

Nature of business

Phone

Workplace address

Accountant's name

Town/suburb

State

Postcode

Accountant's address

Town/suburb

State

Postcode

Estimated earnings loss (give details of how much you believe you have lost and how you calculated the amount. You will be asked to give CTP insurers copies of your taxation returns, group certificates and assessment notices, where available).

45 If you are self employed have you hired anyone to replace you?

No Explain why not Yes Give details of replacement including name, address, duties performed and cost

46 If you were self employed did you have a second paid job before the accident?

Yes Go back to Q43 No

47 Have you received or will you receive any money for being unable to work because of your injuries? (e.g. sick leave or holiday pay, social security benefits, workers compensation or insurance payment.)

No Go to Q48 Yes Give details

48 Before the accident, had you made any firm arrangements to start a new job, stop work, change your duties, working hours or earnings?

No Yes Give details

Please attach a separate page if you need to include more information.

STATUTORY DECLARATION

Please read the statutory declaration carefully before signing.

- The insurer or Nominal Defendant is authorised, under section 74 of the Motor Accidents Compensation Act 1999, to obtain information and documents relevant to the claim from the persons specified in the authorisation.
- You must sign the statutory declaration before a justice of the peace or a solicitor.
- Your claim may be delayed if the statutory declaration is not properly completed and witnessed.
- The injured person must sign the declaration unless he/she is under 18 years or is unable to make the declaration. In this case a parent, guardian, relative or friend of the injured person must sign the declaration.
- All information you have given in the claim form must be true and correct in every respect.
- Under section 117 of the Motor Accidents Compensation Act 1999, you can be penalised up to \$5,500 or imprisonment for 12 months, or both, for knowingly furnishing false or misleading particulars in this form.
- The collection, use and disclosure of personal information by licensed insurers is governed by the National Privacy Principles under the federal Privacy Act 1988.

Declaration

I solemnly and sincerely declare that, to the best of my knowledge, the information given in this Motor Accident Personal Injury Claim Form is true and correct in every respect. I authorise the Nominal Defendant or the insurer, against whom this claim is made, to contact and obtain information and documents relevant to the claim, from:

- any doctor, ambulance service, hospital or other service provider
- any police department
- any property damage insurer
- Centrelink
- any employer or accountant of the injured person
- any personal injury claim or workers compensation insurer
- Lifetime Care and Support Authority (LTCSA)
- Medicare Australia.

I understand that information obtained under this declaration from doctors, an ambulance service or as part of clinical notes from hospitals may include general medical information relevant to my claim.

I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Oaths Act 1900.

Declared before me, on

/ /

Signature of injured person, or person on behalf of the injured person

Signature of solicitor or justice of the peace

Name of injured person, or person on behalf of the injured person

Name of solicitor or justice of the peace

This section to be completed by the solicitor or justice of the peace

Business name (if relevant)

Phone

Address

Town/suburb

State

Postcode

This section to be completed if another person signed for the injured person

Family name

Given name(s)

Relationship to injured person

Phone

Reason why the injured person could not sign

MEDICAL CERTIFICATE

Injured person's information

/ /
Surname/family name Given name(s) Date of birth

Address Town/suburb State Postcode

/ /
Home phone Work phone Mobile phone Date of the accident

Medical information – to be completed by your doctor

"Your doctor" can be your general practitioner, treating specialist or hospital-based doctor

Are the injuries or conditions consistent with the circumstances of the motor accident described to you?

Date of examination / / Yes No

Medical diagnosis or description of injury

Clinical findings (symptoms or results of any investigations)

Did the patient attend hospital? No Yes Name of hospital (if patient attended or was admitted) ▼

Was the patient admitted to hospital? No Yes

Proposed treatment plan

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

Specialist
Medical or therapy
Rehabilitation
Other

Treatment type

Person's name

Phone or contact details

Describe the patient's fitness for work

Fit to resume normal duties on / /

Fit to resume normal duties with restrictions on / / Restrictions

Unfit for work from / / until / / Date of next medical review / /

How long has this patient attended the practice? Has the patient been treated for any similar condition in the past?

Doctor's information

Doctor's name Provider number Work phone Area of specialty

Address of practice Town/suburb State Postcode

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

/ /
Signature Date

CHECK LIST

Before sending this claim form to the CTP insurer please ensure that you have completed the following steps:

- Reported the accident to the police.
- Nominated the motor vehicle and person you consider caused the accident at question 20 (page 10) and attached any relevant documents relating to how the accident happened.
- Found out the CTP insurer of the motor vehicle you consider caused the accident by contacting 1300 656 919.
- Signed the statutory declaration (page 17) in the presence of a solicitor or justice of the peace.
- Ensured that you and your doctor have completed the medical certificate. This completed certificate needs to be sent in with the completed claim form.
- Attached proof of age if you were under 16 years at the date of accident.
- Attached to the claim form any original accounts, receipts or invoices you may already have.
- Made a copy of the claim form, certificates, accounts, invoices, etc for your own record.

Need more information?

Contact the Claims Advisory Service on **1300 656 919** or visit **www.maa.nsw.gov.au**