# Application for Scheduled Benefits

## CLAIM FORM B

**To be completed by, or on behalf of, an injured driver/ passenger/motorcyclist/pillion passenger/pedestrian/cyclist**

**Please also complete Claim Form A – Notice of Accident if you are the injured driver.**


*1st Floor,*
*33 George Street, Launceston*
*PO Box 590, Launceston 7250*
*DX 70112, Launceston*

**TOLL FREE 1800 006 224**

***Telephone: (03) 6336 4800***
***Facsimile: (03) 6336 4848***
***Email: info@maib.tas.gov.au***
***Website: www.maib.tas.gov.au***

# Important Information

Please detach and retain this page for your reference

## *The Motor Accidents Insurance Board*

The Motor Accidents Insurance Board of Tasmania (MAIB) provides third party insurance cover for the benefit of those who suffer personal injury as a result of motor accidents and to insure those whose driving results in motor accidents where personal injury is suffered.

## *No Fault Benefits*

All claims for no fault benefits are processed in accordance with the provisions of the *Motor Accidents (Liabilities and Compensation) Act 1973* ("The Act").

In order to claim no-fault benefits you must:

(a) have suffered "personal injury resulting directly from a motor accident" as defined in the Act; and

(b) report the accident to the police; and

(c) complete an MAIB **Application for Scheduled Benefits** form; and

(d) complete an MAIB **Notice of Accident** form if you were the owner and/or driver of one of the vehicles involved in the accident.

The relevant forms need to be completed and lodged with MAIB as soon as possible as time limits are applicable.

## *Personal Information Protection Statement*

1. Personal information will be collected from you and will be used by the Motor Accidents Insurance Board (MAIB) and its Agents to determine entitlement under the *Motor Accidents (Liabilities and Compensation) Act 1973* and accompanying regulations to common law damages and/or no fault benefits. Information collected may be used by other purposes permitted by the *Personal Information Protection Act 2004.*
2. You are required to provide this information by the *Motor Accidents (Liabilities and Compensation) Act 1973* and the Regulations made under that Act. Failure to provide this information may result in the non acceptance of your claim or services not able to be provided.
3. Personal information and health information may be disclosed if the MAIB needs to make decisions about your entitlements to services or common law damages. In all circumstances, the MAIB would only use your personal information where it is lawful, reasonable and necessary.
4. Personal information may be disclosed to Agents of the MAIB, law enforcement agencies and other organisations that are authorised to collect it.
5. Basic personal information may be disclosed to other public sector bodies where necessary for the efficient storage and use of the information.
6. Personal information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by the individual to whom it relates on request to the MAIB Executive Officer. You may be charged a fee for this service.
7. A copy of the MAIB's Personal Information Protection Policy can be downloaded from the MAIB's website www.maib.tas.gov.au or you can arrange to have a copy posted to you by contacting the MAIB on the details below.

## *Further Information*

Motor Accidents Insurance Board, Level 1, 33 George Street, LAUNCESTON TASMANIA 7250

• **Website**: www.maib.tas.gov.au • **E-mail**: info@maib.tas.gov.au • **Toll Free** 1800 006 224

Interpreter services are available by telephoning Translating and Interpreting Services (TIS) on 13 14 50.

CLAIM NUMBER — — — — — — — — — —

# Application for Scheduled Benefits

# FORM B

**To be completed by, or on behalf of, an injured driver/passenger/ pillion passenger/pedestrian/cyclist**

### Question 1

Do you require the services of an interpreter? NO ☐ YES ☐

If YES, which language

## *Accident Details*

### Question 2

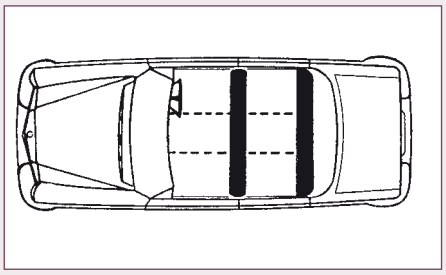
At the time of the accident, were you a:

Driver ☐ Passenger ☐ Motorcyclist ☐ Pillion Passenger ☐ Cyclist ☐ Pedestrian ☐

### Question 3 (Passenger only)

Please indicate on the diagram, your position at the time of the accident.

Mark the position with an **X**



### Question 4

Date of the Accident / / Day of the week Time am/pm

Exact Location of the Accident

Street/s

City/Town State P/Code

### Question 5

Did the accident occur on the way to or from work? NO ☐ YES ☐

### Question 6

Did the accident occur during the course of your work? NO ☐ YES ☐

## Personal Details of Injured Person

### Question 7

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify) _____

Date of Birth ___ / ___ / ___ Male ☐ Female ☐

Surname _____

Given Names _____

Home Address _____

State _____ Postcode _____

Postal Address
*(If same as above, write "as above")*

State _____ Postcode _____

Contact Details

( ) Work Telephone Number

( ) Home Telephone Number

( ) Mobile Telephone Number

( ) Facsimile Number

E-mail Address

How long have you resided in Tasmania? Years Months

Are you known, or have you previously been known by any other name(s), please write name(s) in full.

## Injury Details

### Question 8

Please list all injuries sustained in the accident (e.g. Head – Broken Jaw, Concussion, Cut to left cheek etc, Neck – Whiplash etc)

| Location of Injury | Description of Injury |
|---|---|
| | |
| | |
| | |
| | |

### Question 9

What was the first date of treatment for these injuries? ___ / ___ / ___

### Question 10

Did an ambulance attend the scene? NO ☐ YES ☐

### Question 11

Were you treated for these injuries at a hospital? NO ☐ YES ☐
**(If no, go to Q15)**

### Question 12

Were you admitted to hospital? NO ☐ YES ☐
**(If no, go to Q15)**

### Question 13

If admitted, are you still an inpatient? NO ☐ YES ☐
**(If yes, go to Q15)**

### Question 14

If discharged, date of discharge / /

### Question 15

Name of the doctor, practitioner or hospital who first treated you.

### Question 16

Name and address of your usual General Practitioner?

Are you still receiving further medical treatment? NO ☐ YES ☐

### Question 17

Give full details of any physical disability or health problems existing before the accident

### Question 18

If you have previously lodged a claim for personal injury benefits for any of the following, please tick.

Traffic Accident ☐ Workers' Compensation Claim ☐ Other Claim for Personal Injury ☐

If NO Go to Question 20 If YES Provide full details below:

| Type of Claim | Claim Lodged With | Dates of Injury |
|---|---|---|
| | | / / |
| | | / / |

### Question 19

Are the injuries sustained in this accident of a similar nature to those claimed above? NO ☐ YES ☐

### Question 20

Are there any household duties that you usually perform, but are now unable to? NO ☐ YES ☐

## *Employment Details*

### Question 21

Are you: Employed ☐ Self Employed ☐ A Student ☐ Pensioner ☐ Other ☐

If **employed**

| Occupation(s) | Name and Address of Employer(s) |
|---|---|
| | |

If **self employed**

| Occupation(s) | Name and Address of Registered Business/Businesses |
|---|---|
| | |

If **Other**, please specity

**Question 22**

Has loss of income resulted from injuries sustained? NO ☐ YES ☐

**If no, do not complete questions 23, 24 or 25.**

**Question 23**

Expected period of disability
(eg. 5 days, 3 weeks, 2 months)

**Question 24**

Have you returned to work? NO ☐ YES ☐

**Question 25**

If yes, date returned / /

# IF YOU WERE A DRIVER

- **DO NOT COMPLETE QUESTIONS 26 TO 38 OF THIS FORM. CONTINUE FROM THE DECLARATION ON PAGE 10; AND ALSO**
- **COMPLETE A NOTICE OF ACCIDENT (CLAIM FORM A)**

# IF YOU WERE A PASSENGER/PILLION PASSENGER/PEDESTRIAN/CYCLIST

- **PLEASE CONTINUE FROM QUESTION 26**

## *Accident Details (For Passenger/Pillion Passenger/Pedestrian/Cyclist)*

### Question 26

If a passenger/pillion passenger, please provide details of the **driver/rider of the vehicle/motorcycle in/on which you were travelling** at the time of the accident, or if a pedestrian or cyclist, provide details of the driver/motorcyclist involved.

Surname

Given Names

Home Address

State Postcode

### Question 27

If a passenger/pillion-passenger, please provide details of the **vehicle/motor cycle** in/on which you were travelling at the time of the accident, or if a pedestrian or cyclist, provide details of the **vehicle/motorcycle involved.**

Vehicle Registration Number

State of Australia in which vehicle registered

Make and Model
(*e.g. Holden Commodore VK, Suzuki RGV 250)*

Body Type *(e.g. sedan/coupe/wagon)*

Manual or Automatic Colour

### Question 28 (NOT APPLICABLE IF A PILLION PASSENGER, CYCLIST OR PEDESTRIAN)

If a passenger in a vehicle, were you wearing a seat belt at the time of the accident? NO ☐ YES ☐

If NO, why not?

### Question 29 (NOT APPLICABLE IF A DRIVER, PASSENGER IN A VEHICLE OR PEDESTRIAN)

If a rider of, or pillion passenger on, a motor cycle, or a cyclist, were you wearing a helmet at the time of the accident? NO ☐ YES ☐

If NO, why not?

### Question 30

Please estimate the speed of the vehicle at the time of the accident. klm/hour

### Question 31

Please provide details of all other vehicles involved in the accident (if known).

| Registration Number | Driver's Name, Address (& telephone number if available) | No. of persons in vehicle |
|---|---|---|
| | | |
| | | |
| | | |

## *Accident Details (For Passenger/Pillion Passenger/Pedestrian/Cyclist)*

### Question 32

Provide a written description of how the accident occurred (if more room required - please add an attachment).

### Question 33

Using the following symbols provided, please draw a diagram to indicate how the accident occurred. Include streets, intersections, traffic signs, and point of impact. (Use arrows to show direction in which vehicles were travelling.)

Your vehicle A  Other Vehicle/s B C D etc.  Pedestrians ♀  Point of Impact ✷

## *Reporting of the Accident to Police*

**All motor accidents involving personal injury must be reported to the Police in accordance with the *Motor Accidents (Liabilities and Compensation) Act 1973***

### Question 34

Was the accident reported to the Police? NO ☐ YES ☐

**If yes, please complete questions 35, 36, 37 and 38.**

**If NO, please indicate reason for failure to do so.**

| |
|---|
| |
| |
| |
| |
| |

### Question 35

| | |
|---|---|
| Police Station Reported to: | |
| Date Reported: | |
| Officer's Name: | |
| Officer's Number: | |

### Question 36

Did the Police attend the scene of the accident? NO ☐ YES ☐

### Question 37

Was a breathalyser test conducted? NO ☐ YES ☐

If YES, provide result details.

| |
|---|
| |
| |

### Question 38

Are you aware of any police action being taken or threatened as a result of the accident? NO ☐ YES ☐

If YES,

Details of action pending or taken

| |
|---|
| |

## Declaration

I declare that the information provided in this form is, to the best of my knowledge and belief, a true and correct record of the accident.

Full Name *(please print)*

Signature

Dated / /

(Parent or Guardian must sign if claimant is under 16 years of age)

**If the person completing this form is not the injured person, please provide details.**

Surname

Given Names

Home Address

State Postcode

Contact Details

( )
Work Telephone Number

( )
Home Telephone Number

( )
Mobile Telephone Number

( )
Facsimile Number

E-mail Address

Relationship to Claimant

Reason for completing this form on behalf of claimant

Signature

Dated / /

CLAIM NUMBER_ _ _ _ _ _ _ _ _ _

# Application for Direct Deposit of Payments

Your payments will be deposited direct into your nominated Bank, Building Society or Credit Union account.

Please provide your Account details and return this form to the Motor Accidents Insurance Board ensuring that the details provided are correct.

Incorrect information will cause delays to your payments.

## *Nominated Account Details*

***Note: Deposits will be made to your primary account only.***

Surname of Claimant

Given Names

Date of Birth / /

Street Address

State Postcode

Postal Address

State Postcode

Name of Bank, Building Society or Credit Union into which funds are to be deposited.

Branch where account is held

Branch/BSB Number (6 Digits) (not account number)

Account Number

Account held in the name(s) of

Contact Details

( ) Work Telephone Number

( ) Home Telephone Number

( ) Mobile Telephone Number

( ) Facsimile Number

E-mail Address

EFT payment remittance to be sent to. (Please Tick) E-mail Address ☐ Facsimile Number ☐ Postal Address ☐

Signature of Nominated Signatories

Dated / /

CLAIM NUMBER — — — — — — — — — —

# Authority

To be completed by, or on behalf of, an injured person to allow access to use and disclosure of health and personal information.

## Claimant's Personal Details

Surname of Claimant

Given Names

Home Address

State Postcode

Date of Birth / /

Date of Accident / /

## Medical Authority

To any medical practitioner, health professional or other person who has treated me, or the registrar of any hospital at which I have received treatment.

I hereby authorise you to release to the Motor Accidents Insurance Board, or its agent, any information you may hold relating to injuries suffered by me in a motor accident which occurred on or about the above accident date.

A clear photocopy or imagery reproduction of this authority is to be considered as valid as the original.

Signature Dated / /

## General Authority

I hereby consent to the Motor Accidents Insurance Board or its servants or agents disclosing or using, whether generally or under any Personal Information Act, my Health Information and Personal Information for the purposes of determining my entitlements under the *Motor Accidents (Liabilities and Compensation) Act 1973* and investigating the motor accident which occurred on or about the above accident date.

I also consent to the Motor Accidents Insurance Board obtaining from the Motor Registry or its servants or agents any Personal Information it requires about me, including information relating to my licence and motor vehicle registration details.

A clear photocopy or imagery reproduction of this authority is to be considered as valid as the original.

Signature Dated / /

## If the person completing this form is not the Injured Person, please provide details

Surname

Given Names

Home Address

State Postcode

Relationship to Claimant

Reason for completing this form on behalf of claimant

Signature Dated / /



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