DRIVER PROTECTION COVER CLAIM FORM

WHEN WE WILL PAY A CLAIM

We will pay benefits to the at fault driver of your motor vehicle for injuries suffered (or to the driver's estate or dependants if the driver is killed) as a result of a motor vehicle accident in Australia, if **ALL** of the following apply:

- you have paid your vehicle registration renewal notice sent to you from Queensland Transport, and renew your CTP Insurance with Suncorp
- the driver was solely at fault for the accident and at the time of the accident:
  - was aged 25 years or older, or
  - was aged between 16 years and under 25 years and your motor vehicle is comprehensively insured with us,
- the injury is on our Schedule of Benefits,
- the motor vehicle is a Class 1 (cars and station wagons) or Class 6 (trucks, utilities and vans of 4.5t or less) vehicle, under the Motor Accident Insurance Regulation 2004,
- the accident was the sole or substantial contributing factor to the injury shown on our Schedule of Benefits,
- an appropriately qualified medical practitioner confirms that the driver had sustained the injury as a result of the accident,
- at the time of the accident your motor vehicle was registered, roadworthy and not towing a load over the legal limit, and was not a police vehicle,
- the driver (or the estate or dependants if the driver died) is not entitled to claim under any statutory compensation scheme (including motor accident or workers' compensation).

If ownership of the motor vehicle changes and our Compulsory Third Party policy remains current, this Driver Protection Cover policy transfers to the new owner or owners when the change is registered with Queensland Transport.

WHEN WE WILL NOT PAY A CLAIM

We will not pay benefits if **ANY** of the following applies:

- the injury was intentionally caused or was a result of the accident being intentionally caused, or
- the circumstances causing the injury result in the driver being convicted of a criminal offence, or the driver was under the influence of alcohol or drugs, or had a breath or blood alcohol level over the legal limit, or the driver was involved in any illegal activity, or was on a motor race track, racing, pace making, or in reliability, speed, motor sport or other trials or a car rally at the time of the motor vehicle accident; or
- the injury was directly or indirectly caused by, or was due to, psychological or psychiatric causes, sickness or disease, or
- the injury was caused by revolution, war (whether declared or not), acts of a foreign enemy, military coup, radioactivity or the use, existence or escape of nuclear fuel, nuclear material or waste, or the action of nuclear fission including detonation of any nuclear device or nuclear weapon, biological, bacterial, viral, germ, chemical or poisonous pollutant or contaminant or any looting or rioting following these occurrences.

1. DRIVER DETAILS

Surname	Given Names

Date of Birth	Marital Status		
/ /	☐ Single	☐ Married	☐ Defacto

Address	Post Code

Telephone Number	Policy Number

Has the driver lodged, or does the driver intend to lodge, a claim for compensation from any of the following (if so, please list claim type and claim number):

- Compulsory Third Party Benefits? ☐ No ☐ Yes ______________________________
- Workers Compensation Benefits? ☐ No ☐ Yes ______________________________
- Any other Statutory Scheme (eg entitlements from your employer or from any insurance policies that you may hold or be the beneficiary of)

  ☐ No ☐ Yes ______________________________

2. ACCIDENT DETAILS

Date of Accident	Time of Accident
/ /	AM/PM

Location of Accident	
Suburb/Town	Post Code

Did the driver consume any alcohol and/or drugs in the 12 hrs prior to the accident?

Alcohol: ☐ No ☐ Yes – type ______________	Drugs: ☐ No ☐ Yes – type ________________

Provide a brief description of how the accident occurred:

Please draw a diagram to assist your description:

Who do you think caused the accident, and why?

Vehicles involved in accident (if there are any further vehicles involved, or details you are able to provide, please attach them to this claim form).

Vehicle 1 (the "at fault") vehicle

Registration:		State:	Make/Model:
Driver's Name			
Driver's Address			

Vehicle 2

Registration:		State:	Make/Model:
Driver's Name			
Driver's Address			

Vehicle 3

Registration:		State:	Make/Model:
Driver's Name			
Driver's Address			

3. POLICE REPORT

Did police come to the accident scene?	If no, when was it reported to police?	Police report number:
☐ Yes ☐ No	/ /	

Police officer's name	Police Station

4. WITNESSES

Did any person witness the accident? ☐ Yes ☐ No

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

5. MEDICAL INFORMATION

What injuries are you claiming for from the accident?

- ☐ Quadriplegia
- ☐ Paraplegia
- ☐ Total loss of power of speech
- ☐ Total loss of hearing
- ☐ Permanent and total sight loss in both eyes
- ☐ Loss/amputation of both hands or both feet
- ☐ Loss/amputation of one hand and one foot
- ☐ Loss/amputation of one hand or one foot
- ☐ Permanent and total sight loss in one eye
- ☐ Death (if the driver had dependants)
- ☐ Death (if the driver did not have dependants)

Who has treated you for your injuries? (Please list all doctors, surgeons, physiotherapists etc)

Doctor's name	Speciality	Doctor's address	Last consult date
			/ /
			/ /
			/ /
			/ /
			/ /

Have you suffered any personal injuries, illnesses or disabilities *either before or since the accident* that may affect the extent of the disabilities resulting from the personal injury to which the claim relates or may affect the amount of damages in another way?

☐ No ☐ Yes

If yes, please provide details of the Injuries, illnesses or disabilities:

6. ENCLOSURES

Please ensure that you return the following to Suncorp in the enclosed postage paid envelope *within 6 months of the date of the accident*:

1. Signed Claim Form (and Declaration & Agreement)
2. Signed Medical Authorisation Form
3. Death Certificate & Will of deceased (if claiming Death benefits)

7. DECLARATION and AGREEMENT

I agree to provide Suncorp Metway (within 30 days of a written request) any further information that Suncorp Metway may reasonably require relating to:

- the nature of the injuries resulting from the accident and of any consequent disabilities;
- the medical treatment and rehabilitation services I have sought or obtained;
- my past medical history.

I certify that the answers to the above questions and statements made herein are true to the best of my knowledge and that I have not withheld any fact that may be relevant to this claim.

I authorise and agree that any Medical attendant who has been consulted by me, or any Hospital attended by me, is directed to divulge to Suncorp-Metway or any legal tribunal any information acquired with regard to myself. It is understood in doing so that I waive all professional confidence and provisions of law as to privilege or otherwise forbidding disclosure of such information.

I further agree that Suncorp-Metway may submit such information to any other person if necessary for Claims Administration purposes.

Signature of Driver/Driver's Legal Representative: ………………………….………………..

Date: ……/…………/…………

Signature of Witness: ………………………………………………………

Date: ……/…………/…………

MEDICAL AUTHORISATION FORM

Dear Doctor

SUBJECT: DRIVER PROTECTION COVER CLAIM

I, ...
am lodging a claim with Suncorp Metway for injuries suffered in a motor vehicle accident.

I hereby authorise and request you to divulge to Suncorp Metway information regarding my health and medical history.

It is understood in so doing, that I waive all professional confidence and provisions of law as to privilege or otherwise forbidding disclosure of such information.

Signature:.. **Date:** ..../........../..........

Address: .... **Postcode:**..............................