Insurer's Claim Reference Number

Queensland Compulsory Third Party Insurance (CTP)

Additional Information Form

Motor Accident Insurance Act 1994

Important Notes:

- *The statements of fact contained in this notice of claim must be true, correct and complete. Before you sign the form read it carefully. Your signing of this form is to be witnessed by a Justice of the Peace, Commissioner for Declarations or Solicitor.*
- *Severe penalties apply where false or misleading information is given in CTP scheme claims.*
- *If there is insufficient space to provide the required information, use the additional information page at the back of this form and/or attach additional pages. Please list the question number to which the additional information relates.*
- *This form must be completed and returned within the period ending on the later of the following dates –*
  - *3 months after the motor vehicle accident if the form is requested by the Nominal Defendant in regard to an accident involving an unidentified vehicle;*
  - *in any other claim, 9 months after the motor vehicle accident or the first appearance of symptoms of the injury;*
  - *1 month after the date of the request.*

Additional Information Form (AIF)

1. Claimant

1. Surname/family name

Given names

2. Accident

2. Please advise any additional information to that which was provided in the "Notice of Accident Claim" form and which would assist the insurer to better understand the circumstances and cause of the accident

3. Road conditions (eg, dry sealed road, wet unsealed road, etc.)

4. Weather conditions (eg, fine, heavy rain, sun, etc.)

5. Vehicle 1 (shown on the "Notice of Accident Claim" form)

Registration number

Estimate the speed of the vehicle at the time of the accident. KM/Hour

Number of people in the vehicle (include driver)

What damage was caused to this vehicle?

6. Vehicle 2 (shown on the "Notice of Accident Claim" form)

Registration number

Estimate the speed of the vehicle at the time of the accident. KM/Hour

Number of people in the vehicle (include driver)

What damage was caused to this vehicle?

7. Vehicle 3 (shown on the "Notice of Accident Claim" form)

Registration number

Estimate the speed of the vehicle at the time of the accident. KM/Hour

Number of people in the vehicle (include driver)

What damage was caused to this vehicle?

8. Vehicle 4 (shown on the "Notice of Accident Claim" form)

Registration number

Estimate the speed of the vehicle at the time of the accident. KM/Hour

Number of people in the vehicle (include driver)

What damage was caused to this vehicle?

9. Names, addresses and telephone numbers of any witnesses not listed on the "Notice of Accident Claim" form

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10. If there was an unidentified vehicle involved, advise any information that will assist in its identification (eg, colour of vehicle, unusual features, signwriting.) Also describe how you have tried to find information to assist in its identification (e.g. did you talk to witnesses, advertise for witnesses to contact you or ask the police.)

3. Police Action

11. Are you aware of any Police action arising from the accident

Yes ☐ No ☐

13. If Yes, name of person to be charged

12. If Yes, what part did this person have in the accident

14. If Yes, reason for action

4. Injury and Rehabilitation

15. What injuries did you sustain in the accident? *List all injuries. Be specific (eg, fracture, strain, etc.) and state part of body injured (eg, right index finger, lower back.) If not enough space, write details on a separate page labelled "injuries" and attach to this form*

16. How do the injuries affect you now? *(eg walk with crutches) If not enough space, write details on a separate page labelled "effect of the injuries" and attach to this form*

17. Did you need an ambulance?

No ☐	Yes: Officer's name and station ☐

18. Were you treated at any hospital other than the hospital shown on the Notice of Accident Claim form?

No ☐	Yes: Hospital name and address ☐	Yes: When / / day month year

19. Were you admitted to any hospital other than the hospital shown on the Notice of Accident Claim form?

No ☐	Yes: Hospital name and address ☐	Yes: Date admitted / / day month year

20 Who has treated you for injuries?

List all doctors, surgeons, physiotherapists, etc. If not enough space, write details on a separate page labelled "Doctors etc." and attach it to this form

Name	Address (practice or surgery) Postcode
Name	Address (practice or surgery) Postcode
Name	Address (practice or surgery) Postcode
Name	Address (practice or surgery) Postcode

21. Has rehabilitation been recommended to you? *(For example, counselling, group therapy, work training, independent living assistance, exercise programme)*

No ☐	Yes: what has been recommended ☐

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22. Has a rehabilitation plan been developed for you? No ☐ Yes ☐

23. Have you started rehabilitation?

No ☐ | Yes: what rehabilitation have you had? ☐

24. Who is providing or who is proposed to provide the rehabilitation services?

Name | Address | Postcode

25. Do you plan to start/go on rehabilitation

No ☐ | Yes: what rehabilitation will you have? ☐

5. Financial Loss

26. Have you lost or will you lose wages, salary or business income because of the accident?

No ☐ go to 43 Yes ☐

27. Are you still losing income?

No ☐ Yes ☐

28. Have you returned to work at all since the accident?

No ☐ Yes: ☐ date ___ / ___ / ___ (day / month / year)

29. If not returned to work, when do you expect to return to work?

___ / ___ / ___ (day / month / year) ☐ Don't know

30. What is your usual occupation?

31. List here particulars of your employment during the **three years** prior to the accident and the period since the accident (if self employed see below)

Name and address of employer	Capacity in which employed	Period of employment	Income for period

Self-employed details if applicable

Nature of self-employment	Period of self-employment	Gross earnings per year	Net income per year

32. How many separate periods of time have you been away from work because of the accident (include short periods when you went for treatment)

______ Separate periods

First (or only) period

Work or time lost	From or on	To
--------- weeks --------- days --------- hours	___ / ___ / ___ (day / month / year)	___ / ___ / ___ (day / month / year)

Second period *(if applicable)*

Work or time lost	From or on	To
--------- weeks --------- days --------- hours	___ / ___ / ___ (day / month / year)	___ / ___ / ___ (day / month / year)

Third period *(if applicable)*

Work or time lost	From or on	To
--------- weeks --------- days --------- hours	___ / ___ / ___ (day / month / year)	___ / ___ / ___ (day / month / year)

Fourth period *(if applicable)*

Work or time lost	From or on	To
--------- weeks --------- days --------- hours	___ / ___ / ___ (day / month / year)	___ / ___ / ___ (day / month / year)

If you had more than four separate periods away from work, write details on a separate page labelled "Periods away from work" and attach it to this form

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33. Is the work you do or your weekly income different because of the accident?

No ☐	Yes: Give details ☐

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

No ☐ ▶ Go to 38   Yes ☐

35. Self-employment details

Name of business	Nature of business	Address (workplace) Postcode
Telephone number ( )	**Accountant's name**	**Accountant's address** Postcode

36. Estimated income lost

Give details of how much you believe you have lost and how you calculated the amount. (If necessary, write details on a separate page labelled "Self employment earnings lost" and attach it to this form.) You must be able to give the insurer copies of your taxation returns

37. Is the business still operating No ☐ Yes ☐

Have you hired anyone to replace you

No ☐ *Explain why not in the space below*

Yes ☐ *Give details of replacement – name and address, duties performed, cost. (If necessary, write details on a separate page labelled "Self-employment - replacement " and attach it.)*

38. Have you lost wages or salary, as an employee, because of the accident? No ☐ ▶ go to 40   Yes ☐

39. Employment details

Name of employer (company or organisation)	Address (workplace) Postcode	Contact Person's name
		Contact telephone number ( )

Usual **weekly** working Hours

Ordinary	Overtime

Standard **weekly** earnings

Gross pay	Tax	Net Pay

Description of duties

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40. Did you have a second job before the accident No ☐ ▶ go to 42 Yes ☐

41. Employment details - second job

Name of employer (company or organisation)	Address (workplace)	Contact Person's name
		Contact telephone number
	Postcode	( )

Usual **weekly** working Hours

Ordinary	Overtime

Standard **weekly** earnings

Gross pay	Tax	Net Pay

Description of duties

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

No ☐

Yes: Give details ☐

43. Have you received or will receive any money, because of personal injuries, illnesses and disabilities either before or after the motor vehicle accident? (e.g. Sick leave or holiday pay, social security benefits, worker's compensation, borrowed money, or insurance payment)

No ☐

Yes: ☐ Give details

- If you received a social security benefit, give your social security reference number.
- If workers compensation, give the insurer name and claim number;
- If borrowed, give the lender's name and address;
- If received a payment from an insurer, give the name and address of the insurer and the claims details.

6. Payment to You/Offer of Settlement

44. Are you now in a position to accept payment for your claim? ☐ Yes ☐ No

If Yes, please provide the details of the nature and extent of your loss, and the amount that you would be willing to accept in full satisfaction of your claim

If "No," please advise the reason

In any case, please attach all supporting documentary evidence, such as reports, accounts and receipts that you have.

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7. Declaration and Authorisation

Protection of Privacy

- The information collected by this Additional Information Form, and throughout the course of your claim, is collected in accordance with the *Motor Accident Insurance Act 1994 and Regulations.*
- The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to help the administration of the statutory insurance scheme and the detection of fraud.
- The information collected by this Additional Information Form, and throughout the course of your claim, may be disclosed in accordance with the *Motor Accident Insurance Act 1994 and Regulations* to such bodies as the Motor Accident Insurance Commission, 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 the personal information held as provided by the *Privacy Act 1988 (C'th)*, or if the information is held by the Queensland Government you are able to gain access to the information as provided by the Queensland Government Information Standard number 42.

Authority to obtain information

The injured person must complete all of the information required in this Additional Information Form.

† This form must be signed by the injured person unless he/she is either under the age of 18 years or unable to complete it. In these cases it must be completed and signed by an agent of the injured person, such as a parent, guardian, relative or friend. The signing of this form constitutes the injured person's written permission to allow the insurer to obtain records or information that may affect his/her claim (including information on his/her pre-accident circumstances). Persons and entities from whom information may be obtained from or provided to include:

- other licensed insurers
- an insurer carrying on the business of providing CTP insurance, workers' compensation insurance, personal accident or illness insurance, or insurance against the loss of income through disability
- a department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws
- a hospital (including a private hospital)
- the ambulance service or other emergency service
- a doctor, professional provider of rehabilitation services or person professionally qualified to assess cognitive, functional or vocational capacity
- an employer (or previous employer)
- an educational institution

(Note: An insurer includes a reinsurer and/or overseas reinsurer)

Under Section 87 of the *Motor Accident Insurance Act 1994* a person can be fined up to $11,250 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information given in the Additional Information Form must be true, correct and complete.

I hereby authorise the insurer against whom this claim is made or the claim manager to contact those persons and entities aforementioned and to obtain information and documents relevant to the claim.

I hereby authorise those persons or entities listed in this section, particularly doctors who have treated me for my injuries and hospitals where I have been treated for my injuries, to provide information and documents to the insurer or the claim manager against whom this claim is made.

I understand this declaration and authorisation and I declare that to the best of my knowledge and belief the statements of fact contained in this Additional Information Form (including the attached pages) are true, correct and complete in every respect.

Signature of Injured Person Date / /

† Signature of Agent (if injured person is unable to sign) Date / /

Witness of Signature

Sworn/Affirmed before me

Signature of Justice of the Peace, Commissioner for Declarations or Solicitor | Date / / | Place

Surname/Family Name of Witness | Given Names of Witness

Address of Witness | Postcode | Telephone

† Agent of Injured Person

If another person signs on behalf of the injured person:

Surname/Family Name of Agent | Given Names of Agent

Address of Agent | Postcode | Telephone

Relationship to the injured person | Reason why the injured person could not sign

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