MAIC Motor Accident Insurance Commission

QUEENSLAND COMPULSORY THIRD PARTY (CTP) INSURANCE

Additional Information Form

Motor Accident Insurance Act 1994

Important notes

- The statements contained in this form must be true, correct and complete. Your signing of this form is to be witnessed by a Justice of the Peace, Commissioner for Declarations or lawyer.
- Severe penalties apply where false or misleading information is given.
- If there is insufficient space to provide the required information, use the additional information page at the back of this form or attach additional pages.
- This form must be completed and returned within **one (1) month** after it is requested by the insurer.
- Please ensure you and your witness have initialled the bottom of every page.

1. Injured person

1. Surname/family name

Given name/s

2. If you have already provided a Medicare number ▸ Go to **5**. If you do not have a Medicare number, what is your:

Passport number

Country of issue

3. At the date of the accident, were you in Australia on a visa? ☐ Yes ☐ No

▸ If yes,

Visa number

Subclass

Visa expiry date / MM/YY

Date of arrival / / DD/MM/YYYY

Date of departure / / DD/MM/YYYY

4. Are you currently residing in Australia on a visa? ☐ Yes ☐ No

▸ If yes,

Visa number

Subclass

Visa expiry date / MM/YY

Date of arrival / / DD/MM/YYYY

▸ **I declare that all information contained within this Additional Information Form is true, correct and complete.**
Initial of claimant _____ Initial of JP/C.Dec/lawyer _____.
If you lodge a fraudulent claim, you may be prosecuted.

2. Accident

5. Please provide 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.

6. Road surface (e.g. sealed/unsealed)

7. Road conditions (e.g. wet, dry, slippery)

8. Atmospheric conditions (e.g. clear, foggy)

9. Lighting conditions (e.g. dark/light, street lighting, lit/unlit)

10. **Vehicle 1 (as shown on the Notice of Accident Claim Form)**

Registration number

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

What damage was caused to this vehicle?

11. **Vehicle 2 (as shown on the Notice of Accident Claim Form)**

Registration number

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

What damage was caused to this vehicle?

12. **Vehicle 3 (as shown on the Notice of Accident Claim Form)**

Registration number

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

What damage was caused to this vehicle?

13. **Vehicle 4 (as shown on the Notice of Accident Claim Form)**

Registration number

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

What damage was caused to this vehicle?

14. If there was an unidentified vehicle involved, provide any information that will assist in its identification (e.g. colour of vehicle, unique features, signwriting).

15. If there was an unidentified vehicle involved, provide details of how you have tried to identify the vehicle (e.g. contacting or advertising for witnesses).

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3. Police action

16. Are you aware of any police action arising from the accident? ☐ Yes ☐ No

▸ If yes, against who?

Surname/family name

Given name/s

What role did this person have in the accident?

What is the police action?

4. Injury and rehabilitation

17. What injuries did you sustain in the accident? Be specific and state body part injured (e.g. fractured right index finger, strained lower back).

If not enough space, write details in the additional information section of this form or on a separate page and attach to this form.

18. How do the injuries affect you now? (e.g. walk with crutches).

If not enough space, write details in the additional information section of this form or on a separate page and attach to this form.

19. Did you need an ambulance?

☐ No ☐ Yes

▸ Officer's name

▸ Officer's station

20. Were you treated at and/or admitted to any hospital other than the hospital shown on the Notice of Accident Claim Form?

☐ No ☐ Yes

▸ Hospital name

▸ Hospital address

Street type

Suburb/town | State | Postcode

▸ Date/s treated

▸ Hospital name

▸ Hospital address

Street type

Suburb/town | State | Postcode

▸ Date/s admitted

21. Is the medical practitioner who completed the medical certificate (which accompanied the Notice of Accident Claim Form), your usual treating General Practitioner (GP)?

☐ Yes ☐ No

▸ If no, usual treating GP name

▸ GP address

Street type

Suburb/town | State | Postcode

▸ Email

▸ Best contact number ( )

▸ **I declare that all information contained within this Additional Information Form is true, correct and complete.**
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22. Who has treated you for your injuries? List all doctors, surgeons and allied health providers.
If not enough space, write details in the additional information section of this form or on a separate page and attach to this form.

Treatment provider 1

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

Treatment provider 2

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

Treatment provider 3

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

Treatment provider 4

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

Treatment provider 5

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

Treatment provider 6

Name

Hospital/practice name

Address of hospital/practice

	Street type	
Suburb/town	State	Postcode

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5. Financial loss

23. Have you lost or will you lose wages, salary or business income because of the accident? ☐ Yes ☐ No ▸ Go to **42**

24. Are you still losing income? ☐ Yes ☐ No

25. Have you returned to work at all since the accident? ☐ No ☐ Yes ▸ If yes, when? / / DD/MM/YYYY

26. If you have not returned to work, do you expect to return to work? ☐ Yes ☐ No ☐ Don't know

▸ If yes, when? / / DD/MM/YYYY

27. What is your usual occupation?

28. List the particulars of your employment during the **three** years prior to the accident **and** the period **since** the accident

Financial year	Name of employer	Address of employer	Net income
20			$
20			$
20			$
20			$
20			$

Self-employed details *(if applicable)*

Financial year	Name of business	Nature of business	Net income
20			$
20			$
20			$
20			$

29. Have you had any periods of time away from work because of the accident? ☐ Yes ☐ No ▸ Go to **30**

	Weeks	Days	Hours	From	To
First period of absence				/ / DD/MM/YYYY	/ / DD/MM/YYYY
Second period of absence *(if applicable)*				/ / DD/MM/YYYY	/ / DD/MM/YYYY
Third period of absence *(if applicable)*				/ / DD/MM/YYYY	/ / DD/MM/YYYY
Fourth period of absence *(if applicable)*				/ / DD/MM/YYYY	/ / DD/MM/YYYY

If you had more than four separate periods away from work, write details in the additional information section of this form or on a separate page and attach to this form.

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

☐ No ☐ Yes ▸ Give details

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31. Have you lost income from self-employment because of the accident? ☐ Yes ☐ No ▸ Go to **37**

32. Self-employment details

Name of business

Nature of business

ABN

Address (workplace)

	Street type	
Suburb/town	State	Postcode

33. Accountant details

Name of firm

Accountant's name

Address

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

34. Give details of how much income you estimate you have lost and how you calculated the amount.
If necessary, write details in the additional information section of this form or on a separate page labelled and attach to this form.

35. Is your business still operating? ☐ Yes ☐ No

36. Have you hired anyone to replace you? ☐ Yes ☐ No

If yes, give details of replacement – name and address, duties performed and cost. If no, explain why not.

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37. Have you lost wages or salary, as an employee, because of the accident? ☐ Yes ☐ No ▸ Go to **39**

38. Employment details

Name of employer (company or organisation)

Contact person's name

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Usual **weekly** working hours

Ordinary Overtime

Usual net (after tax) weekly earnings $

Description of duties

39. Did you have a second job before the accident? ☐ Yes ☐ No ▸ Go to **41**

40. Employment details – second job

Name of employer (company or organisation)

Contact person's name

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Usual **weekly** working hours

Ordinary Overtime

Usual net (after tax) weekly earnings $

Description of duties

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

☐ No ☐ Yes ▸ Give details

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

☐ No ☐ Yes

▸ Give details

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

6. Payment to you/offer of settlement

43. Are you in a position to accept payment to finalise 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 to finalise your claim. If no, please advise the reason in the box below.

Please attach any receipts, documents, medical reports, photographs or other evidence to support your claim. Remember to keep a copy for your own records.

▸ **I declare that all information contained within this Additional Information Form is true, correct and complete.**
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7. Declaration

Protection of privacy

- The information collected by this Additional Information Form, and throughout the course of your claim, is collected and handled in accordance with the *Motor Accident Insurance Act 1994* and *Motor Accident Insurance Regulation 2018*, and may be disclosed to such bodies as the Motor Accident Insurance Commission (MAIC), the Nominal Defendant, and other insurers or parties involved in the assessment of your claim.
- The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents and to assist MAIC in administering the statutory insurance scheme and carrying out its functions under the *Motor Accident Insurance Act 1994* and *Motor Accident Insurance Regulation 2018*.
- 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 *Information Privacy Act 2009*.

Under Section 87U of the *Motor Accident Insurance Act 1994* (Qld) a person can be fined up to 150 penalty units (which, as at 1 July 2019 is $20,017.50) or be imprisoned for up to one (1) year for knowingly providing false or misleading statements and/or documents in and with this form and in connection with the claim generally. All information you provide in the Additional Information Form must be true, correct and complete. Refer to the *Penalties and Sentences Act 1992* (Qld) for the value of a penalty unit.

I understand this declaration 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 and I make this declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

Signature of injured person	Date
	/ / DD/MM/YYYY
± Signature of agent (if injured person unable to sign)	Date
	/ / DD/MM/YYYY

Taken and declared before me – Justice of the Peace (JP)/Commissioner for Declarations (C. Dec)/lawyer

Signature	Place	Date
		/ / DD/MM/YYYY

Surname/family name of JP/C.Dec/lawyer	Given name/s of JP/C.Dec/lawyer

Qualification of witness (JP/C.Dec/lawyer)	Seal of office (if applicable)

± Agent of injured person

If another person signs on behalf of the injured person

Surname/family name of agent	Given name/s of agent

Address of agent

	Street type	
Suburb/town	State	Postcode

Best contact number	Email address
( )	

Relationship to the injured person	Details of injured person's legal incapacity

Additional information

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