

ACCIDENT NOTIFICATION FORM



State Insurance
Regulatory Authority

THIS FORM IS APPROVED BY THE STATE INSURANCE REGULATORY AUTHORITY. IT IS TO BE USED FOR NOTIFICATIONS MADE UNDER THE MOTOR ACCIDENTS COMPENSATION ACT 1999 FOR ACCIDENTS ON OR AFTER 1 APRIL 2010

If you have been injured in a motor vehicle accident in NSW, you may be immediately entitled to up to \$5,000 for your treatment expenses and lost earnings regardless of who was at fault.

You need to:

1. identify the registration number of the vehicle that caused the accident
2. report the accident to the police if they did not attend the accident scene and obtain a police event number
3. complete the declaration on page 5 and get your doctor to complete the medical certificate
4. call 1300 656 919 to find out the Green Slip or Compulsory Third Party (CTP) insurer of the vehicle that caused the accident
5. send your completed form to the CTP insurer within 28 days of the accident

The insurer will let you know within 10 days whether it will pay for your reasonable and necessary treatment expenses and lost earnings and will provide you with a reference number that must be used in all correspondence.

Your information is confidential

The information in this form will be treated confidentially. Only staff of the State Insurance Regulatory Authority (SIRA), 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 SIRA or CTP insurers. If you consider:

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

CTP insurers are bound by the Australian Privacy Principles. You may visit the licensed insurers' website 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.

Interpreter service

If you need an interpreter to help you understand this form, contact Associated Translators & Linguists on **02 9231 3288** during office hours.

Need more information?

If you have any questions, would like more information or need help completing this form, contact the State Insurance Regulatory Authority's Claims Advisory Service on **1300 656 919** or visit sira.nsw.gov.au

**THIS FORM MUST BE COMPLETED AND SENT TO THE CTP INSURER
WITHIN 28 DAYS OF THE ACCIDENT**

INFORMATION FOR PEOPLE INJURED IN A MOTOR VEHICLE ACCIDENT

How do I complete this form?

You can only submit one Accident Notification Form so you will need to decide which vehicle you think caused the accident (or the vehicle that you think was most at fault) and provide the registration number of this vehicle.

You will also need to provide:

- the police event number,
- the registration numbers of other vehicles involved in the accident, and
- a brief description of the accident and details of your role in it

If you are seeking reimbursement for your lost earnings you must provide details of your employment situation and income before the accident as well as details of any income you have lost as a result of your injuries. The insurer may ask you for additional information to verify your income loss. This additional information can include things such as pay slips, tax returns or information from your employer confirming your employment details.

You are required to make a declaration on page 5 that your injuries are a direct result of the motor accident. By signing the declaration you will also be giving the insurer permission to contact and obtain information from individuals or organisations about the information provided in this form.

This form also includes a medical certificate, which must be completed by your doctor. It will include details of your injuries, the results of any medical investigations and recommended treatment in addition to certifying the period of time off work you will need.

Where do I send the form?

Send the Accident Notification Form to the Compulsory Third Party (CTP) insurer of the vehicle that caused the accident. If you don't know who this insurer is, contact the State Insurance Regulatory Authority's Claims Advisory Service on 1300 656 919 for assistance.

What do I do if I was the driver at fault?

The Accident Notification Form provides for treatment expenses and lost earnings up to \$5,000 regardless of who was at fault. If you were the driver at fault, you should send your completed Accident Notification Form to the CTP insurer of the vehicle you were driving at the time of the accident. You can still access the benefits available under the Accident Notification Form, however you may not be eligible to make a full claim for compensation under the Motor Accidents Scheme.

What happens if I can't lodge my Accident Notification Form on time?

If you cannot lodge your Accident Notification Form within 28 days of the accident you will need to make a full claim by lodging a Personal Injury Claim Form. Remember, you may not be eligible to make a full claim if you were the driver at fault.

What if I can't identify the registration number of the vehicle that caused the accident?

You cannot use this form if you are unable to identify the vehicle that caused the accident, for example, if your accident was a 'hit and run'. You will need to complete a Personal Injury Claim Form instead. Contact the State Insurance Regulatory Authority's Claims Advisory Service on 1300 656 919 for assistance.

What happens once the insurer receives my Accident Notification Form?

The insurer will let you know within 10 days whether they admit 'provisional' liability in relation to your motor vehicle accident. Provisional liability means that the insurer accepts responsibility for the cost of your treatment expenses and lost earnings, up to \$5,000. It does not mean that they will agree to pay other expenses or compensation.

The insurer will provide you with a reference number to assist you to access treatment and to be used in all correspondence with the insurer.

What treatment expenses will the insurer pay for?

Once provisional liability is admitted, the insurer is obliged to pay for treatment expenses that are reasonable and necessary. The insurer may use approved treatment guidelines to decide what is reasonable and necessary.

What do I do with my treatment accounts?

Your treatment accounts should be sent to the insurer, including the account for completion of the medical certificate by your doctor, as soon as possible after you receive them. You should make sure that all accounts are clearly marked with your name and the reference number given to you by the insurer.

When will the insurer pay me for my lost earnings?

The Accident Notification Form provides a combined total of \$5,000 for treatment provided and loss of income sustained within six months of the date of the accident. In paying these expenses, the insurer must give priority to payment of treatment expenses which means they will pay these expenses before making any payment for lost earnings. For this reason, the insurer will not make payment for any loss of income until the end of the six month period following the accident.

What happens if my expenses are greater than \$5,000?

If your treatment expenses and lost earnings are more, or are likely to be more than \$5,000 in the first six months you may need to make a full claim for compensation under the Motor Accidents Scheme (see 'Am I eligible to make a full claim?').

You may also like to make a full claim if you wish to claim other compensation such as payment for your pain and suffering.

Am I eligible to make a full claim?

You may be eligible to make a full claim under the Motor Accidents Scheme if:

- you can demonstrate that a driver or owner of a motor vehicle, other than yourself, was partially or completely at fault
- you were injured in a blameless accident, for example, an accident resulting from the sudden illness of the driver, such as heart attack or stroke, or vehicle failure such as a tyre blow-out.

If you were under 16 years old at the time of the accident and residing in NSW, you may be able to make a full claim for hospital, medical, rehabilitation, pharmaceutical, respite care and attendant care expenses regardless of who was at fault.

You may **not** be eligible to make a full claim if you were the driver completely at fault.

For more information about who can make a full claim for compensation, contact SIRA's Claims Advisory Service on **1300 656 919**.

When should I make a full claim?

You should make a full claim by submitting a Personal Injury Claim Form to the CTP insurer if:

- you are unable to lodge the Accident Notification Form within 28 days
- you cannot identify the vehicle that caused the accident

To make a full claim, **you must submit a Personal Injury Claim Form no later than six months from the date of the accident.** Your claim may not be accepted if it is not received within six months. You can obtain the claim form from the insurer of the vehicle that caused the accident or you can download it from sira.nsw.gov.au

What happens to my Accident Notification Form if I make a full claim?

If you make a full claim by lodging a Personal Injury Claim Form, the insurer does not have to make any further payments under the Accident Notification Form.

What compensation can I get if I make a full claim?

Depending on the circumstances of your accident, you may be entitled to compensation that includes:

- reasonable and necessary medical, pharmaceutical, rehabilitation, respite care and attendant care expenses
- other expenses and economic losses e.g. loss of income and out of pocket expenses
- non-economic loss (payment for your pain and suffering) if you have a serious, permanent injury

ACCIDENT NOTIFICATION FORM – TO BE COMPLETED BY THE INJURED PERSON

Personal Details

Surname/family name Given name(s) Date of birth / / Sex M F

Address

Phone numbers Email
Home: Work: Mobile:

Occupation Name of employer

Have you ever suffered an injury to the same part of your body prior to this motor vehicle accident? No Yes

Details

Have you already submitted an Accident Notification Form in relation to this motor vehicle accident? No Yes

Insurance Company: Claim or reference number:

Have you submitted a Personal Injury Claim Form in relation to this motor vehicle accident? No Yes

Insurance Company: Claim or reference number:

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 Yes Please give details if you can

Type of claim Date of injury / / Insurance company Claim or reference number

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

Details of this accident

Date of accident / / Time of accident am/pm Place of accident – include street, town or suburb and state

Name of police officer attending the accident Police station Police 'event' number

You must report this accident to Police. [If you have a copy of the Police Report please attach it to this form.](#)

Your part in the accident: Driver Passenger Motorcycle rider Pillion passenger Cyclist Pedestrian Other

1) Vehicle causing the accident

Registration No. State Make Driver & phone No. Owner

2) Vehicle you were travelling in

Registration No. State Make Driver & phone No. Owner

3) Other vehicle/s involved in the accident if known

Registration No. State Make Driver & phone No. Owner

ACCIDENT NOTIFICATION FORM – TO BE COMPLETED BY THE INJURED PERSON

Diagram of the accident

Brief description of the accident

Was an ambulance called?

No Yes ▶ Were you: Treated at the scene only Transported to hospital

Had you taken any drugs, including medication or alcohol in the 12 hours before the accident?

No Yes ▶ Give details of type and amount

Employment Details (relating to loss of income)

If you are seeking reimbursement for lost earnings, the insurer may ask you for additional information or they may contact your employer to confirm your employment details.

Your employment situation before the accident

Self employed Full time employed Part time employed Retired
 Casual Student/child Home duties Not working
 Other Pensioner
Please describe Please describe

Have you taken time off work because of the injuries you sustained in the accident? No Go to Declaration Yes

Work time lost From / / To / /

Have you returned to work?

Yes No ▶ When do you expect to return to work? / / Don't know
 Fully? Partly? (e.g. light/modified duties) Date of return / /

Name of employer Contact person's name Contact phone number

Workplace address

Employer's email address (if known) Town/suburb State Postcode

ACCIDENT NOTIFICATION FORM – TO BE COMPLETED BY THE INJURED PERSON

Usual weekly working hours

Ordinary

Overtime

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

Pay before tax (gross)

Pay after tax (net)

Description of duties

Have you received or will you receive 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)

Yes No Go to Declaration



Give details (e.g. insurer, claim number, contact name, if known)

Declaration

Please read the declaration carefully before signing.

- This declaration allows the insurer to obtain relevant records or information relating to this form, including any information about treatment you have received from a doctor or hospital.
- This declaration must be signed by the injured person unless he/she is under 18 or unable to make the declaration. In that case, the declaration must be made by a parent, guardian, relative or friend on the injured person's behalf.
- It is an offence under the Motor Accidents Compensation Act 1999 to knowingly make a false or misleading statement in this form. 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.

I declare that to the best of my knowledge the information given in the Accident Notification Form is true and correct in every respect and my injuries are a direct result of the motor accident.

I authorise the Nominal Defendant or the insurer against whom this notification is made to contact and obtain information and documents relevant to an injury/condition to which this notification relates from:

- any doctor, ambulance service, hospital or other service/treatment provider
- any police department
- any property damage insurer
- any employer or accountant of the injured person
- any personal injury claim or workers compensation insurer
- Lifetime Care and Support Authority of NSW

Name

Signature

Date

If the declaration has been signed on behalf of the injured person, please provide details:

Relationship to injured person

Phone contact

Reason injured person could not sign

This form must be sent to the CTP insurer within 28 days of the accident.

MEDICAL CERTIFICATE – TO BE COMPLETED BY TREATING DOCTOR

AMA fees apply for all medical services. Fee for completing forms: \$32

Injured person's surname/family name Given name(s) Date of birth / /

Date of accident / / Date of examination / / Are the injuries/conditions consistent with the circumstances of the motor accident described to you? Yes No

Medical diagnosis and description of the injury

Clinical findings (symptoms, results of any investigations)

Did the patient attend hospital? No Yes Length of stay Name of hospital?

Was the patient admitted to hospital? No Yes

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

Refer to:
Specialist
Therapy
Other
Type Name of person Phone number or contact details

Describe the patient's fitness for work:
Fit to resume normal duties on / /
Fit for alternative duties on / / Please describe
Unfit for work from / / To / /

Does the patient have any other co-morbidities or previous injuries? No Yes
Please describe

How long has this patient attended the practice?

Date of next medical review / / Does the patient need an interpreter? No Yes Language

Doctor's name (please print) Provider number

Address of practice

 Postcode
Phone number () () Fax number () ()
Area of specialty

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

Signature Date / /

For further information or forms contact the State Insurance Regulatory Authority on 1300 656 919