Insurer's Claim Reference Number

Queensland Compulsory Third Party Insurance (CTP)

Notice of Accident Claim Form

(Fatal Injury)

for accidents occurring on and after 1st October 2000

Motor Accident Insurance Act 1994

Important Notes:

- *Part A of this form is to be completed if the claim is only for funeral and other expenses. Otherwise Parts A and B must be completed.*
- *Police report information is required to complete this form.*
- *The statements of fact contained in this notice of accident claim must be true, correct and complete. Before you sign the form read it carefully. Your signing of Part A of this form is to be witnessed by a person over the age of 18 years and to whom you are known. Your signing of Part B of this form is to be witnessed by a Justice of the Peace, Commissioner for Declarations or a Solicitor/Lawyer.*
- *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.*

What you need to do

Police Reporting

- There must be an official Police record of the motor vehicle accident before you complete this form. Ensure that you have the Police accident report reference number.

Complete This Form/Where to Send It

- Use this form to make a claim for loss/expenses as a relative/dependant of a **person who sustained fatal injury** in a motor vehicle accident which was wholly or partly the fault of some other person.
- If you suffered personal injury in a motor vehicle accident which was wholly or partly the fault of some other person, use the Notice of Accident Claim Form (Non-Fatal Injury) (not this form.)
- If only Part A of this form is completed, you are required to make the declaration and authorisation by signing your name in section 8 at the end of Part A. Your signing is to be witnessed by a person over 18 years of age, who knows you. If Part A and B are completed, then you are required to make the sworn declaration and authorisation at the end of Part B only.
- Send the completed form to the **insurer** of the motor vehicle at fault. To obtain the name and address of that insurer, **contact the Enquiry line**. When calling, you should have details of the accident and registration number of the motor vehicle/s owned/driven by the person/s at fault. This information will assist the search.
- If the motor vehicle at fault is **uninsured (unregistered) or unidentified**, send the completed form to the **Nominal Defendant**, GPO Box 2203, Brisbane Q 4001. Unless indicated otherwise, the term insurer, when used in CTP claims, includes the Nominal Defendant.

Time Limits

- **Lodge this form with the insurer** (or, if the motor vehicle is **uninsured/unregistered**, the Nominal Defendant) as soon as possible. Your claim could be rejected if the insurer or the Nominal Defendant receives it more than **nine (9) months** after the date of accident or the first appearance of symptoms of the injury.
- **If an unidentified motor vehicle is involved in the accident**, this form must be lodged with the Nominal Defendant within **three (3) months** of the date of accident, unless there is a reasonable excuse for the delay. **In any circumstance**, your claim must be lodged with the Nominal Defendant within **nine (9) months** of the date of the accident or it will be **barred**.
- **If you do retain a solicitor/lawyer, then within one (1) month of the first consultation with the solicitor/lawyer**, this claim form must be given to the insurer against whom the claim is to be made. This does **not** extend the time limits referred to above.

  Late lodgement: *If notice is not given within the time fixed by the Motor Accident Insurance Act 1994, your excuse for the delay must be given in the Additional Information/Excuse for Delay section at the back of this form or by separate notice to the insurer.*

What happens then

- **The insurer is required to contact you within fourteen (14) days** of receiving this claim form fully completed.
- **You must be prepared to help the insurer with its consideration** of your claim. You may be required to provide specific information, photographs, documents or records.
- **If your claim can be finalised, you can discuss this with the insurer and agree on the payment to you**. If you are unsure of your legal rights, a solicitor/lawyer can advise what needs to be done and how much it will cost.

Information/CTP Enquiry Line

- The regulatory authority for the CTP scheme is the Motor Accident Insurance Commission which can be contacted by mail at GPO Box 2203, Brisbane Q 4001; by telephone on 1300 302 568; by fax on (07) 3220 6689; or online at www.maic.qld.gov.au.
- If you need information on the claims process or CTP scheme, then contact the Enquiry Line on 1300 302 568.

Part A: Funeral and other expenses

1. Claimant

Surname/family name

Given names

Ever been known by any other name? ☐ Yes ☐ No

If Yes, advise other surname/family name

Other given names

Gender ☐ Male ☐ Female

Date of birth / / DD/MM/YYYY

Marital status ☐ Single ☐ Married ☐ De Facto

Home address | Suburb/town | State | Postcode

Postal address | Suburb/town | State | Postcode

Email Address

Telephone

Home ( ) | Work ( ) | Mobile

What was your relationship to the deceased?

☐ Spouse (including de facto partner) ☐ Dependant ☐ Other:

Employment status

☐ Employed ☐ Retired ☐ Home duties ☐ Student/child ☐ Not working

Occupation (If Employed)

2. Deceased

Surname/family name

Given names

Ever been known by any other name? ☐ Yes ☐ No

If Yes, advise other Surname/family name

Other given names

Gender ☐ Male ☐ Female

Date of birth / / DD/MM/YYYY

Marital status ☐ Single ☐ Married ☐ De Facto

Former home address | Suburb/town | State | Postcode

Has death certificate been signed? ☐ No ☐ Yes If Yes, attach a certified copy to this form

Date of death / / DD/MM/YYYY

Time of death : ☐ AM ☐ PM HH:MM

3. Accident

Date of accident / / DD/MM/YYYY

Time of accident : ☐ AM ☐ PM HH:MM

Place of accident – include name of nearest cross road or property number

Suburb/Town | State | Postcode

What was the deceased's part in the accident (driver, passenger, cyclist, pedestrian, other)?

If the deceased's part required the use of a seatbelt or helmet, was it being worn?

If the deceased was in or on a vehicle, what was its registration number and state?

Reg. no. | State

Had the deceased had any alcohol or drugs in the last 12 hours before the accident?

☐ No ☐ Don't Know ☐ Yes: Type Amount When

Who caused the accident and why?

Describe what happened.

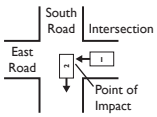
Draw a diagram to assist your description

Symbols: ← 1 vehicle that caused the accident

← 2 ← 3 other vehicle(s)

Diagram must be manually drawn

Example Diagram



Vehicles in the accident (If more than 2 vehicles, please provide the details on the additional information page at the back of this form)

Vehicle 1 ***(Vehicle 1 is the one considered the Most At Fault vehicle)***

Registration number | State | Year of manufacture | Make (e.g. Ford)

Model (e.g. Laser) | Body type (e.g. Sedan) | Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know Drugs: ☐ Yes ☐ No ☐ Don't know

Vehicle 2

Registration number | State | Year of manufacture | Make (e.g. Ford)

Model (e.g. Laser) | Body type (e.g. Sedan) | Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know Drugs: ☐ Yes ☐ No ☐ Don't know

4. Witness

Did any person witness the accident?

☐ Yes ☐ No

If Yes, please advise the name, address and telephone number of each witness (include persons in same vehicle as deceased):

Name	Address	Telephone Number
		( )
		( )
		( )
		( )

5. Police/Ambulance/Hospital

Did Police come to the scene of the accident?

☐ Yes ☐ No

If No, when was the accident reported to Police?

/ /
DD/MM/YYYY

Police accident report reference number

Police officer's name

Police station

Did an ambulance attend the accident?

☐ Yes ☐ No

If Yes, officer's name and station

Was the deceased transported to a hospital?

☐ Yes ☐ No

If Yes, hospital name and address

Was the deceased, prior to death, admitted to hospital?

☐ Yes ☐ No

If Yes, was hospitalisation longer than 24 hours?

☐ Yes ☐ No

6. Solicitor/Lawyer

Have you retained a solicitor/lawyer?

☐ Yes ☐ No

If Yes, date of first consultation

/ /
DD/MM/YYYY

If Yes, please advise name and address of legal firm.

Name		
Address		
Suburb/town	State	Postcode

7. Funeral and other costs

Are you in a position to accept payment for your claim?

☐ Yes ☐ No

If Yes, please provide the nature and extent of your loss, and the amount that you will accept in full satisfaction of your claim.
If No, please advise the reason.

Funeral cost	Other costs	**Total**
$	$	$

In any case, please attach all supporting documents that you have. Supporting documents include reports, accounts and receipts.

8. Declaration and Authorisation – Part A only

Protection of Privacy

- The information collected by this Notice of Accident Claim 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 2004*, 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, such as those indicated below.
- 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 2004*, which include conducting research about the scheme and detecting fraud.
- 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 *Information Privacy Act 2009*.

Authority to obtain information

Do NOT complete this declaration and authorisation if you are completing Part B of this form.

† This form must be signed by the claimant 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 claimant, such as a parent, guardian, relative or friend. The signing of this form constitutes the claimant's written permission to allow the insurer to obtain records or information that may affect his/her claim. 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
  - the Office of the Director of Public Prosecutions
  - the Legal Services Commission
  - the Queensland Workers' Compensation Regulatory Authority
  - National Injury Insurance Agency Queensland

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

Under Section 87U of the *Motor Accident Insurance Act 1994* a person can be fined up to $17,670.00 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 Notice of Accident Claim 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 the deceased for injuries and hospitals where the deceased had been treated for 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 Notice of Accident Claim Form (including the attached pages) are true, correct and complete in every respect.

Signature of Claimant

Date / / DD/MM/YYYY

† Signature of Agent (if Claimant unable to sign)

Date / / DD/MM/YYYY

Witness of signature

I am over the age of 18 years and certify that the claimant/claimant's agent signing this form is known to me by the stated name on this form and I have witnessed their signing of this form

Signature of Witness | Date / / DD/MM/YYYY | Place

Surname/family name of Witness | Given names of Witness

Address of Witness | Suburb/town | State | Postcode | Telephone ( )

† Agent of Claimant

If another person signs on behalf of the Claimant

Surname/family name of Agent | Given names of Agent

Address of Agent | Suburb/town | State | Postcode | Telephone ( )

Relationship to the Claimant | Reason why the Claimant could not sign

Part B: Dependency

Claim history

1. (a) Have you (or the deceased) ever made a claim for damages for a personal injury? ☐ Yes ☐ No

   (b) In respect to personal injury, illness or disability (or its symptoms) that existed for a period of more than four (4) weeks, have you (or the deceased) ever:

   – made a claim for damages, social security benefits or compensation? ☐ Yes ☐ No

   – received any amount by way of damages, social security benefits or compensation? ☐ Yes ☐ No

   If Yes to any question, please provide the details of the injury, illness, disability, damages, benefit and/or compensation:

Relationship

2. What was your relationship to the deceased?

   ☐ Spouse (including de facto partner) ▶ Go to **3** Other ▶ Go to **11**

   ☐ Dependant (including claim on behalf of dependant, e.g., guardian, etc.) ▶ Go to **7**

Spouse

3. Details of surviving spouse *(including de facto partner)*

   Your date of marriage / / DD/MM/YYYY

   Place of marriage

   Note: A copy of your marriage certificate must be lodged with this notice of claim.

   Date your de facto relationship commenced / / DD/MM/YYYY

   Note: Acceptable evidence of your relationship is required.

4. Your employment details

   Usual occupation

   Are you currently employed? ☐ No ☐ Yes ▼

   Give details of nature of employment and name and address of current employer

Nature	Name	
Address		
Suburb/town	State	Postcode

   Weekly income

Gross income	Tax	Net income
$	$	$

   Do you have any separate source of income?

   ☐ No ☐ Yes ▶ Nature of separate source of income

   Weekly income

Gross income	Tax	Net income
$	$	$

5. Have you any current health problems? ☐ No ☐ Yes ▼*(give details)*

6. What were the average weekly payments and/or other financial benefits provided to you by the deceased prior to the accident?

Other Dependants

7. Details of the other dependant persons
   Complete the following details for all dependant children and other dependant persons (excluding the surviving spouse).

Dependant 1

Surname/family name

Given names

Marital status

☐ Single ☐ Married ☐ De Facto

Date of birth

/ /
DD/MM/YYYY

Gender

☐ Male ☐ Female

Relationship to deceased

Full-time student

☐ No ☐ Yes

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of separate source of income

Weekly income

Gross income	Tax	Net income
$	$	$

Does the dependant reside with the claimant?

☐ Yes ☐ No ▶ Home address

Suburb/town	State	Postcode

Home telephone number ( )

Dependant 2

Surname/family name

Given names

Marital status

☐ Single ☐ Married ☐ De Facto

Date of birth

/ /
DD/MM/YYYY

Gender

☐ Male ☐ Female

Relationship to deceased

Full-time student

☐ No ☐ Yes

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of separate source of income

Weekly income

Gross income	Tax	Net income
$	$	$

Does the dependant reside with the claimant?

☐ Yes ☐ No ▶ Home address

Suburb/town	State	Postcode

Home telephone number ( )

Dependant 3

Surname/family name

Given names

Marital status

☐ Single ☐ Married ☐ De Facto

Date of birth

/ /

DD/MM/YYYY

Gender

☐ Male ☐ Female

Relationship to deceased

Full-time student

☐ No ☐ Yes

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of separate source of income

Weekly income

Gross income	Tax	Net income
$	$	$

Does the dependant reside with the claimant?

☐ Yes ☐ No ▶ Home address

Suburb/town	State	Postcode

Home telephone number ( )

Dependant 4

Surname/family name

Given names

Marital status

☐ Single ☐ Married ☐ De Facto

Date of birth

/ /

DD/MM/YYYY

Gender

☐ Male ☐ Female

Relationship to deceased

Full-time student

☐ No ☐ Yes

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of separate source of income

Weekly income

Gross income	Tax	Net income
$	$	$

Does the dependant reside with the claimant?

☐ Yes ☐ No ▶ Home address

Suburb/town	State	Postcode

Home telephone number ( )

If more than four dependants write details on a separate page labeled "Details of other dependant persons" and attach it to this form.

8. Do any of the dependants have any current health problems?

☐ No ☐ Yes ▼

Provide full details, including name of dependant and the nature of the health problem.

9. What were the average weekly payments and/or other financial benefits provided to each of the abovenamed dependants by the deceased prior to the accident?

Name of Dependant	Weekly payment/benefit
	$
	$
	$
	$

Name of dependant	Weekly payment/benefit
	$
	$
	$
	$

10. Has the claimant or any dependant applied for or received any money or benefit arising out of the accident?
For example, social security benefits, worker's compensation, borrowed money or insurance payment.

☐ No ☐ Yes

▼ *Give full details (including amounts):*
- *if social security benefit give the social security reference number;*
- *if workers' compensation, give the insurer and claim number;*
- *if money borrowed, give the lender's name and address;*
- *if payment from an insurance company, give the name and address of the insurer and the policy number.*

Additional accident details

11. Details of the accident.

Weather conditions

Road conditions

12. Is Police action going to be taken?

☐ Yes ▼ ☐ No ☐ Don't know

Surname of person charged (or to be charged)

Charge

Vehicle registration number

Court

13. Was there any unidentified vehicle involved?

☐ Yes ▼ ☐ No ☐ Don't know

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 (eg, did you talk to witnesses, advertise for witnesses to contact you or ask the police.)

Medical and employment details

14. If treatment was provided to the deceased prior to death, who was/were the principal treating doctor/s?

Name

Address *(practice or surgery)*

Suburb/town	State	Postcode

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

15. Had the deceased suffered any personal injuries, illnesses or disabilities either before or after the accident that may affect this claim in any way?

☐ No ☐ Yes ▶ Date / / DD/MM/YYYY

Injuries, illnesses or disabilities

Doctor/Hospital name

Address	Suburb/town	State	Postcode

16. What was the deceased's employment situation before the accident?

☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Home duties ☐ Full-time student

☐ Other:

17. If the deceased was self-employed, give details

Name of business

Nature of business

Address (workplace)	Suburb/town	State	Postcode

Accountant's name

Accountant's address	Suburb/town	State	Postcode

18. Is the business still operating? ☐ No ☐ Yes

19. Usual occupation details of the deceased

20. Employment details of deceased at date of accident

Name of employer *(company or organisation)*

Address (workplace)	Suburb/town	State	Postcode

Contact person's name

Contact telephone number ( )

Usual **weekly** working hours

Ordinary

Overtime

Description of duties

Gross weekly income	Tax	Net income
$	$	$

21. Did the deceased have a second paid job before the accident?

☐ No ▶ Go to **23** ☐ Yes

22. Employment details – second job

Name of Employer *(company or organisation)*

Address (workplace)	Suburb/town	State	Postcode

Contact person's name

Contact telephone number ( )

Usual **weekly** working hours

Ordinary

Overtime

Description of duties

Gross weekly income	Tax	Net income
$	$	$

23. Did the deceased have any other source of income?

☐ No ☐ Yes ▶ Nature of separate source of income

Gross weekly income	Tax	Net income
$	$	$

24. List here particulars of the deceased's employment during the **three years** prior to the accident and the period (if any) after the accident (if self employed see below.)

Name and address of employer			Period of employment	Capacity in which employed	Earnings for period
Name					
Address					
Suburb/town	State	Postcode			
Name					
Address					
Suburb/town	State	Postcode			
Name					
Address					
Suburb/town	State	Postcode			

Self employed details (if applicable)

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

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

☐ No ☐ Yes ▶ Give details

Payment to You/Offer of Settlement

26. Are you 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.

Sworn Declaration and Authorisation

This declaration and authorisation requires completion when you use both Part A and Part B of this form. There is no need to complete the declaration and authorisation at the end of Part A when you complete this declaration and authorisation at the end of Part B.

The claimant must have completed all of the information required in Part A and B of this Notice of Accident Claim Form. It must be sworn/affirmed before a Justice of the Peace, Commissioner for Declarations or Solicitor.

Protection of Privacy

- The information collected by this Notice of Accident Claim 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 2004*, 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, such as those indicated below.
- 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 2004*, which include conducting research about the scheme and detecting fraud.
- 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 *Information Privacy Act 2009*.

Authority to obtain information

† This form must be signed by the claimant unless he/she is either under the age of 18 years or unable to complete it. In these cases it must be completed by an agent of the claimant, such as a parent, guardian, relative or friend. The signing of this form constitutes the claimant's written permission to allow the insurer to obtain records or information that may affect the claim. Persons and entities from whom information may be obtained 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
- the deceased's employer(s)
- an educational institution
- the Office of the Director of Public Prosecutions
- the Legal Services Commission
- the Queensland Workers' Compensation Regulatory Authority

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

Under Section 87U of the Motor Accident Insurance Act 1994 you can be fined up to $17,670.00 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information you have given in the Notice of Accident Claim 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 understand this declaration and authorisation and I swear/affirm that to the best of my knowledge and belief the statements of fact contained in this Notice of Accident Claim Form (including the attached pages) are true, correct and complete in every respect.

Signature of Claimant

Date / / DD/MM/YYYY

† Signature of Agent (if Claimant unable to sign)

Date / / DD/MM/YYYY

Witness of signature
Sworn/Affirmed before me

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

Surname/family name of Witness | Given names of Witness

Address of Witness | Suburb/town | State | Postcode | Telephone ( )

† Agent of Claimant
If another person signs on behalf of the Claimant:

Surname/family name of Agent | Given names of Agent

Address of Agent | Suburb/town | State | Postcode | Telephone ( )

Relationship to the Claimant | Reason why the Claimant could not sign

Additional vehicles

Vehicle 3

Registration number | State | Year of manufacture | Make (e.g. Ford)

Model (e.g. Laser) | Body type (e.g. Sedan) | Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know

Drugs: ☐ Yes ☐ No ☐ Don't know

Vehicle 4

Registration number | State | Year of manufacture | Make (e.g. Ford)

Model (e.g. Laser) | Body type (e.g. Sedan) | Colour

Name, address and telephone number of the owner

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Name, address and telephone number of the driver/rider

Name	Address		
Suburb/town	State	Postcode	Telephone ( )

Had the driver/rider had any alcohol and/or drugs in the last 12 hours before the accident?

Alcohol: ☐ Yes ☐ No ☐ Don't know

Drugs: ☐ Yes ☐ No ☐ Don't know

Additional information/excuse for delay