MAIC Motor Accident Insurance Commission

QUEENSLAND COMPULSORY THIRD PARTY (CTP) INSURANCE

Notice of Accident Claim Form (Non-Fatal Injury)

Motor Accident Insurance Act 1994

Important notes

- The statements contained in this Notice of Accident Claim Form, including attachments, must be true to the best of your knowledge. You must sign this form in the presence of an eligible witness. For further information on who can witness your signature, please visit **maic.qld.gov.au/witness-signing-fact-sheet**.
- Time limits for CTP claims apply (refer to page 2).
- 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/s at the back of this form or attach additional pages.

Checklist

☐ You have reported the accident to a police officer and have a police accident report reference number.
☐ You have identified the insurer of the at-fault motor vehicle.
☐ The medical certificate in this form has been completed by a doctor.
☐ If you have retained legal representation to act on your behalf, this form is accompanied by a Law Practice Certificate that has been completed and verified by the supervising principal of the law practice.
For further information on Law Practice Certificates, please visit **maic.qld.gov.au/legal-practitioners**.
☐ The claimant certificate in this form has been completed by you and verified by statutory declaration.
☐ You have signed this form in the presence of an eligible witness.
☐ A certified colour identity document of the injured person is attached.
☐ You have kept all referrals and/or receipts for rehabilitation or treatment to provide to the CTP insurer.
☐ You have checked the box at the bottom of every page confirming that the information is true to the best of your knowledge.
☐ You have sent your completed form to the CTP insurer of the motor vehicle at fault. To find the relevant insurer, see page 2.

1. What you need to do

Police reporting

- Before lodging a claim for injury resulting from a motor vehicle accident, the accident must be reported to a police officer. When completing this claim form you will require the following details: the name of the police officer who attended the accident scene (or to whom the accident was reported), the police station where the police officer was stationed and the police accident report reference number.

Complete this form/where to send it

- Use this form **if you personally suffered an injury** in a motor vehicle accident which was wholly or partly the fault of some other person.
- Use this form if you are acting as an agent on behalf of an injured person who is under the age of 18 or under a legal incapacity (all of the answers to questions contained in the form must relate to the injured person).
- To make a claim as a relative/dependant, for loss resulting from a person sustaining a **fatal injury**, use the Notice of Accident Claim Form (Fatal Injury) (not this form).
- Send the completed form to the CTP insurer of the motor vehicle at fault. To obtain the name and address of that insurer, **contact the MAIC Enquiry Line on 1800 287 753 or visit www.maic.qld.gov.au.** When calling, please have the details of the accident, including the registration number of the motor vehicle/s responsible for causing the accident. 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 Qld 4001. Unless indicated otherwise, the term insurer, when used in CTP claims, includes the Nominal Defendant.

Time limits

- **Lodge this form with the relevant CTP insurer** as soon as possible. Your claim could be rejected if the CTP insurer 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 retain legal representation, this claim form must be given to the CTP insurer against whom the claim is to be made **within one (1) month of the first consultation.** This does not extend any of 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 must be given in the Additional information/excuse for delay section at the back of this form or by separate statutory declaration.**

What happens then

- **The CTP insurer is required to contact you within fourteen (14) days** of receiving your claim form with a decision on whether or not your claim form is a satisfactory notice and whether or not the CTP insurer is prepared to meet your reasonable and appropriate rehabilitation expenses.
- **You must be prepared to help the CTP insurer with its consideration** of your claim. You may be required to give specific information, photographs, documents or records and you may have to have a medical examination or assessment.
- **You must also take all reasonable steps** to recover from your injury by having reasonable and appropriate treatment and rehabilitation, and to reduce your lost income – for example, by seeking alternative work. Contact the CTP insurer or your legal representative to discuss reasonable and appropriate rehabilitation options.
- **If your claim can be finalised, you can discuss this with the CTP insurer and agree on the payment to you.** If you are unsure of your legal rights, a lawyer can advise you.

2. Injured person

Title

Surname/family name

Given name/s

Former names/if known by other names

Date of birth

/ /

DD/MM/YYYY

Marital status

☐ Single ☐ Married ☐ De facto

Gender

Best contact number

( )

Email address

Home address (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Postal address *(if different from home address)*

	Street type	
Suburb/town	State	Postcode

Do you hold a Medicare card?

☐ Yes ☐ No

If yes, Medicare number

– –

Ref

Do you require an interpreter?

☐ Yes ☐ No ◆ If yes, language

Have you made an application to the National Injury Insurance Scheme Queensland? ☐ Yes ☐ No

Are you a participant in the National Injury Insurance Scheme Queensland? ☐ Yes ☐ No

Do you have any personal injury, illness or disability (either before or since the accident) that may affect the extent of the disability resulting from the personal injury to which this claim relates or may affect the amount of damages in any other way? ☐ Yes ☐ No

Have you ever sustained a significant disability*? ☐ Yes ☐ No

For a significant disability*, have you 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

*Significant disability means any personal injury, illness or disability that either:

– May be relevant to the assessment of the extent of the injury suffered by the injured person in the accident; OR

– Lasted (or its symptoms lasted) for four (4) weeks or more.

If yes to any question, please provide details of the injury, illness, disability, damages, entity claim was made against, benefit and/or compensation.

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

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

Address

	Street type	
Suburb/town	State	Postcode

What was your role in the accident?

☐ Driver/rider ☐ Passenger/pillion ☐ Cyclist ☐ Pedestrian

☐ Other, please specify:

If your role required the use of a seatbelt or helmet, were you wearing one? ☐ Yes ☐ No

If you were in or on a vehicle, what was its vehicle registration number and state of registration?

Vehicle registration number

State

Had you had any alcohol or drugs (including prescription drugs) in the last 12 hours before the accident?

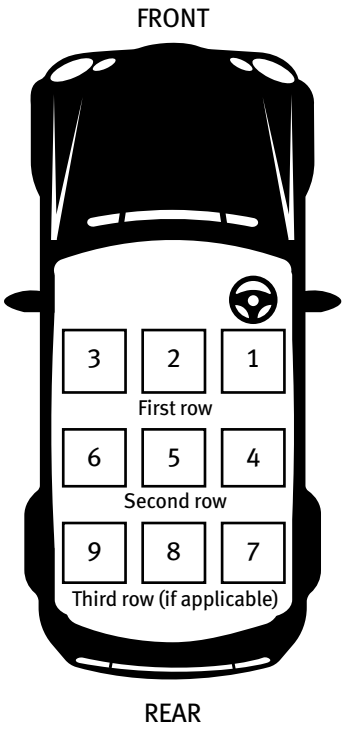
Alcohol ☐ No ☐ Yes ◆ If yes Type Quantity

Drugs ☐ No ☐ Yes ◆ If yes Type Quantity

If you were in or on a vehicle how many occupants, including the driver, were in or on that vehicle?

If you were in a car, utility or truck, mark your seating position on the diagram to the right with an X.
Mark other occupants with an O.

Describe how the accident happened. Who caused it and why are they to blame?

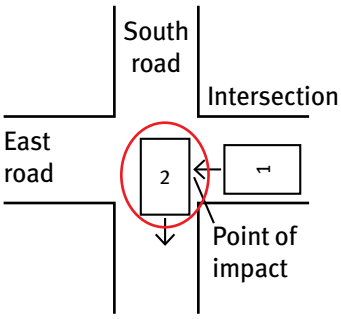


If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

Draw a diagram to assist your description. Mark the vehicle you were in by circling it (if applicable). Number the vehicles as shown in the example diagram. Vehicle 1 should be the vehicle that most caused the accident.

Example diagram



Was a property damage claim lodged for the vehicle you were travelling in? ☐ Yes ☐ No ☐ Don't know

If yes, which insurer was the claim lodged with?

Policy number (if known)

Claim number (if known)

Vehicles in the accident

Vehicle 1 (Vehicle 1 is the vehicle considered most responsible for causing the accident)

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

Model (e.g. Camry) | Body type (e.g. sedan) | Colour

Name of owner

Address of owner (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Surname/family name of driver/rider

Given name/s of driver/rider

Address of driver/rider (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Had the driver/rider had any alcohol or drugs (including prescription drugs) in the last 12 hours before the accident?

Alcohol ☐ No ☐ Yes ☐ Don't know

Drugs ☐ No ☐ Yes ☐ Don't know

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

Vehicle 2

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

Model (e.g. Camry) | Body type (e.g. sedan) | Colour

Name of owner

Address of owner (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Surname/family name of driver/rider

Given name/s of driver/rider

Address of driver/rider (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Had the driver/rider had any alcohol or drugs (including prescription drugs) in the last 12 hours before the accident?

Alcohol ☐ No ☐ Yes ☐ Don't know

Drugs ☐ No ☐ Yes ☐ Don't know

If more than 2 vehicles, please provide the details on the additional information page/s at the back of this form.

4. Witness

Did any person witness the accident? ☐ Yes ☐ No

Surname/family name of witness

Given name/s of witness

Address of witness (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

Surname/family name of witness

Given name/s of witness

Address of witness (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email address

If more than 2 witnesses, please provide the details on the additional information page/s at the back of this form.

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

5. Police report

Did the police come to the scene of the accident? ☐ Yes ☐ No

If not, you must report the accident to a police officer.

Date reported to police
/ /
DD/MM/YYYY

Police accident report reference number

Police station

Police officer's name

6. Employment at date of accident

Have you lost, or will you lose wages, salary, business or other income because of the accident? ☐ Yes ☐ No

Occupation

Employment status
☐ Full time ☐ Part time ☐ Casual ☐ Other:

Employed

Name of employer

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Self-employed

Name of business

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Have you returned to work?
☐ No ☐ Yes ◆ If yes, date returned to work / /
DD/MM/YYYY

If not employed or self-employed, what was your employment status?
☐ Seeking work ☐ Child ☐ Student ☐ Retired ☐ Home duties ☐ Not employed (health reasons)
☐ Other:

If not employed or self-employed, what was the source of your income?

Weekly gross (before tax) income

Average weekly gross (before tax) income for the last 12 months

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

Have you made (or will you make) a workers' compensation, income protection or any other type of claim for your injury? ☐ Yes ☐ No

◆ If yes, name of insurer

Claim number

7. Legal representation

When did you first consult a lawyer about the possibility of making a claim? / / DD/MM/YYYY

☐ I have not consulted a lawyer

Have you retained a law practice?

☐ No ☐ Yes ◆ If yes, date law practice retained to act / / DD/MM/YYYY

◆ If yes, please advise name of law practice

Law practice name

8. Payment to you/offer of settlement

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.

9. Identification

You must attach a certified copy of an identity document issued by a government which contains a colour photograph of you and which is current. This identity document is required to be certified by a lawyer, notary public, Commissioner for Declarations or a Justice of the Peace.

If you do not hold identification of this type, please attach a colour, passport-sized photograph of yourself taken within the last two years. This photograph should be a full-face view of your head and shoulders and be of good quality. This photograph is required to be certified by a person who has known you for at least one (1) year. They must write on the back or below the photograph: 'This is a true photograph of [your name]' and write their full name, the date and sign the photograph below this statement.

The above identification requirements only apply to claimants who are aged 15 and over.

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

10. Declaration and authorisation

Protection of privacy

- The information collected by this Notice of Accident Claim Form, and through the course of your claim, is collected and handled in accordance with the *Motor Accident Insurance Act 1994* and the *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, 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 2018*, which include conducting research about the scheme and detecting fraud.
- Failure to provide all or part of the information may delay or prevent the progress 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

The claimant must complete all the information required in this Notice of Accident Claim Form.

± This form may be signed by the injured person, an agent of the injured person (if the injured person is under the age of 18 or under a legal incapacity) or a substitute signatory (if the injured person directs them to sign the form). If you require further information about who can sign this form, you should visit **maic.qld.gov.au/substitute-signing-fact-sheet**. The signing of this form constitutes the injured person's written permission to allow the insurer to obtain records or information that may affect their claim (including information on their 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, personal accident or illness insurance, or insurance against the loss of income through disability (Note: An insurer includes a reinsurer and/or overseas reinsurer)
- 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 services 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

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 2022, is $21,562.50) 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 Notice of Accident Claim Form must be true to the best of your knowledge. Refer to the *Penalties and Sentences Act 1992* (Qld) for the value of a penalty unit.

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 to provide information and documents to the insurer or the claim manager against whom this claim is made.

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

I have read and understood the contents of this form, including attachments. By virtue of the provisions of the *Oaths Act 1867*, I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge. I understand that a person who provides a false matter in a declaration commits an offence.

Signature of: ☐ **Injured person** or ☐ **Agent of injured person** or ☐ **Substitute signatory**

Date

/ /
DD/MM/YYYY

If signing as substitute signatory*:

☐ I confirm I have been directed by the injured person/agent to sign this form and I have legal capacity.

Surname/family name of injured person

Given name/s of injured person

Date of birth of injured person

/ /
DD/MM/YYYY

Date of accident

/ /
DD/MM/YYYY

Taken and declared before me**

Signature of witness

Place

Date

/ /
DD/MM/YYYY

Surname/family name of witness

Given name/s of witness

Address where claim form witnessed (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Qualification of witness

Seal of office (if applicable)

± Details of agent of injured person (if applicable)

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

Reason why the injured person cannot sign

± Details of substitute signatory (if applicable)

Surname/family name of substitute signatory

Given name/s of substitute signatory

Relationship to the injured person/agent

Reason why the injured person/agent cannot sign

*** For further information on who can be a substitute signatory, please visit maic.qld.gov.au/substitute-signing-fact-sheet.**

**** For further information on who can witness this form, please visit maic.qld.gov.au/witness-signing-fact-sheet.**

Medical Certificate

This Medical Certificate is to accompany your Notice of Accident Claim Form and must be completed by a medical practitioner.

For information about Queensland's Compulsory Third Party (CTP) insurance scheme and completing the Medical Certificate, phone the MAIC Enquiry line on 1800 287 753 or visit maic.qld.gov.au/for-health-providers/providing-medical-certificates.

Injured person

Surname/family name

Given name/s

Date of birth

/ /
DD/MM/YYYY

Medical information

Date of accident

/ /
DD/MM/YYYY

Date of initial examination by a doctor

/ /
DD/MM/YYYY

Did you physically examine the injured person? ☐ Yes ☐ No

◆ If yes, on what date? / /
DD/MM/YYYY

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

Was the injured person an existing patient of yours, or your medical practice, as at the date of the accident? ☐ Yes ☐ No

Medical diagnosis and description of injury

Clinical findings (symptoms, results of any investigations, and details of treatment/rehabilitation to date)

Was the injured person treated at a hospital? ☐ Yes ☐ No

Name of hospital

If the injured person was admitted to hospital, was it for longer than 24 hours? ☐ Yes ☐ No

Did the injured person require an ambulance? ☐ Yes ☐ No

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

Initial of medical practitioner

Proposed treatment plan

Treatment likely to be required

☐ Nil ☐ Short term (‹6 weeks) ☐ Medium term (6 – 12 weeks) ☐ Long term (›12 weeks)

Details of treatment plan (including recommendations and advice to patient)

Referred to	Type	Name of person/practice	Best contact number
☐ Specialist			
☐ Therapy			
☐ Other			

Describe the injured person's fitness for work

☐ Fit to resume normal duties on / / DD/MM/YYYY

☐ Fit for alternative duties on / / DD/MM/YYYY

☐ Unfit for work from / / DD/MM/YYYY to / / DD/MM/YYYY

Date of next medical review / / DD/MM/YYYY

Medical practitioner's information

Medical practitioner's name

Professional qualification

Medicare provider number

AHPRA registration number

Telephone number ( )

Hospital/practice name

Email address

Hospital/practice address (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

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 / / DD/MM/YYYY

Claimant Certificate

Pursuant to section 18(2) of the *Motor Accident Insurance Regulation 2018*. Statutory Declaration made pursuant to the *Oaths Act 1867*.

Notice to claimant

You are required to sign this certificate to the best of your knowledge in the presence of an eligible witness.
If you require further information about why you need to sign the certificate or have any concerns about the certificate, you should visit **www.maic.qld.gov.au/for-injured-people**.

I, _____ of _____

in the State or Territory of _____, do solemnly and sincerely declare that:

1. I am the claimant in respect of a claim for damages for personal injury arising from a motor vehicle accident which occurred on ___/___/___ ("the claim").
DD/MM/YYYY

2. I make this claim on my own initiative.

Please check the box which applies to this claim:

☐ 3A. I was not personally approached or contacted by a person and solicited or induced to make this claim; **OR**

☐ 3B. I was personally approached or contacted by a person and solicited or induced to make this claim.
The name and contact details of this person are as follows:

_____

The circumstances in which this person approached or contacted me are as follows (e.g. in person, by telephone, email or other form of communication and by whom and when):

_____

Please check the box which applies to this claim:

☐ 4A. I have not retained a law practice to act for me in relation to the claim; **OR**

☐ 4B. I am not aware of the law practice that I have retained giving consideration (i.e. a fee, gift or benefit) to a person for my referral to, or engagement of, this law practice; **OR**

☐ 4C. I am aware of the law practice that I have retained giving consideration (i.e. a fee, gift or benefit) to a person for my referral to, or engagement of, this law practice. The details of this consideration are as follows (e.g. amount paid, amount paid to whom):

_____

I have read and understood the contents of this form. By virtue of the provisions of the *Oaths Act 1867*, I declare that the contents of this form are true. Where the contents of this form are based on information and belief, the contents are true to the best of my knowledge. I understand that a person who provides a false matter in a declaration commits an offence.

Signature of claimant/substitute signatory _____ Date ___/___/___
DD/MM/YYYY

If signing as substitute signatory*:

☐ I confirm I have been directed by the claimant to sign this form and I have legal capacity.

Taken and declared before me**

Signature of witness _____ Place _____ Date ___/___/___

Surname/family name of witness _____ Given name/s of witness _____

Qualification of witness (e.g. JP, C.Dec, lawyer, etc) _____ Seal of office (if applicable)

± Details of substitute signatory (if applicable)

Surname/family name of substitute signatory _____ Given name/s of substitute signatory _____

Relationship to the claimant _____ Reason why the claimant cannot sign _____

*** For further information on who can be a substitute signatory, please visit maic.qld.gov.au/substitute-signing-fact-sheet.**

**** For further information on who can witness this form, please visit maic.qld.gov.au/witness-signing-fact-sheet.**

Additional information/excuse for delay

Additional vehicles

Vehicle 3

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

Model (e.g. Camry) | Body type (e.g. sedan) | Colour

Name of owner

Address of owner (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( ) | Email address

Surname/family name of driver/rider | Given name/s of driver/rider

Address of driver/rider (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( ) | Email address

Had the driver/rider had any alcohol or drugs (including prescription drugs) in the last 12 hours before the accident?

Alcohol ☐ No ☐ Yes ☐ Don't know

Drugs ☐ No ☐ Yes ☐ Don't know

Vehicle 4

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

Model (e.g. Camry) | Body type (e.g. sedan) | Colour

Name of owner

Address of owner (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number ( ) | Email address

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.

Surname/family name of driver/rider

Given name/s of driver/rider

Address of driver/rider (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Best contact number

( )

Email address

Had the driver/rider had any alcohol or drugs (including prescription drugs) in the last 12 hours before the accident?

Alcohol

☐ No ☐ Yes ☐ Don't know

Drugs

☐ No ☐ Yes ☐ Don't know

Additional information/excuse for delay

If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ I declare that the contents of this form, including attachments, are true. Where the contents of this form, including attachments, are based on information and belief, the contents are true to the best of my knowledge.