CTP INSURANCE REGULATOR

Government of South Australia

South Australia Compulsory Third Party (CTP) Insurance

Motor Accident Injury Claim Form

Important information
Give as much detail as you can when completing this form. Providing detailed, accurate information about the accident and your injuries helps in the quick and efficient processing of your claim.

Use page 10 of this form if you need to include more information or attach additional page(s).

Complete and submit this form **within six months** of the accident, or as soon as reasonably practicable if the at-fault vehicle was unable to be identified or was unregistered at the time of the accident.

What you need to complete this form
You need to know the number plate of the at-fault vehicle to find out which CTP Insurer will manage your claim. You can use the **EzyReg CTP Insurer** search function (enter this term into your web browser to find it) and enter the accident date and vehicle's plate number. You can call the CTP Regulator on **1300 303 508** for help with this.

If the at-fault vehicle is unknown or unregistered as at the accident date, send your form to the CTP Regulator. It will allocate the form to a CTP Insurer and advise you which CTP Insurer will manage your claim.

Help completing this form
Contact the CTP Insurer of the at-fault vehicle for help. Visit the CTP Regulator's website **www.ctp.sa.gov.au** for insurer details and information about the claims process.

After completing this form
Send it to the CTP Insurer of the at-fault vehicle. They will give you a claim number, allocate a claims consultant to your claim, send you a confirmation letter, and discuss any reasonable and necessary treatment. Treatment may start before liability has been determined.

Interpreter help
If you need an interpreter please telephone the Interpreting and Translating Centre on 1800 280 203 and ask to be connected to the CTP Regulator on 1300 303 558, 9:00am to 5:00pm Monday to Friday, excluding public holidays.

What you need to do to complete this form

Completing this form will be easier if you follow the below points in the order they are listed.

- ☐ Obtain a vehicle collision report number from the police – **page 6**
- ☐ Give the medical certificate at the back of this form to a doctor (e.g. GP or hospital doctor) to complete – **page 13**
- ☐ Attach proof of identity and age. This must include a copy of your driver's licence if you were a driver in the accident. Other documents can be used if you were not a driver e.g. a copy of your birth certificate or passport – **page 3**
- ☐ Attach breath, drug, and blood alcohol analysis documents if relevant and where available – **page 4**
- ☐ Attach evidence of loss of income or earning capacity (e.g. payslips) if claiming loss of income – **page 8**
- ☐ Attach original receipts if claiming reimbursement for expenses – **page 9**
- ☐ Make a copy of the completed form and attachments for your records.
- ☐ Send to the CTP Insurer of the at-fault vehicle as soon as possible.

Injured person

1. Is another person assisting you to complete this form? Yes ☐ If yes, please give details No ☐

Name of person who is providing assistance

Reason injured person needs assistance

Details of injured person

2. Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other ☐ If other, please give title

Family name

Given name(s)

Have you been known by another name *(e.g. maiden name, alias)*? Yes ☐ If yes, please give details No ☐

Family name

Given name(s)

3. Date of birth

4. Gender Male ☐ Female ☐ Another term (please specify)

5. Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐ Prefer not to say ☐

6. Driver's licence number

Please attach a copy of your driver's licence if you were a driver in the accident. Other documents can be used if you were not a driver as proof of identity and age e.g. a copy of your birth certificate or passport

7. Home address

Postcode

Postal address *(if different from home address)*

Postcode

8. Best contact phone number

9. Best contact email

10. Do you have a Medicare card? Yes ☐ No ☐

If yes, Medicare number

Ref

– –

You should have a Medicare card if you are an Australian or New Zealand citizen living in Australia, or if you are a permanent resident

11. What is your country of birth?

12. Would you like an interpreter to help you with your claim?

Yes ☐ If yes, language No ☐

This will inform the CTP Insurer how to discuss your claim with you effectively

Please continue on page 10 or attach additional page(s) if required.

Accident

13. Date of accident

14. Time of accident

15. Place of accident *(e.g. street, suburb, intersection)*

16. Road surface at the place of accident Sealed ☐ Unsealed ☐
Road conditions at the place of accident Wet ☐ Dry ☐

17. Traffic conditions at or near the place of accident
Heavy ☐ Medium ☐ Light ☐

18. Traffic controls nearest the place of accident
Stop sign ☐ Give way sign ☐ Traffic light ☐ Roundabout ☐ None ☐

19. Weather conditions
Fine ☐ Rain ☐ Fog ☐

20. How many motor vehicles were involved in the accident?

21. Name of your vehicle repairer (if applicable)

22. Name of your vehicle insurer (if applicable)

23. Are there any video or photographs of the accident scene or vehicle damage? Yes ☐ If yes, please give to the insurer
No ☐ Unknown ☐

24. What was your role in the accident?
Driver/rider ☐ Passenger/pillion ☐ Cyclist ☐ Pedestrian ☐ Other ☐ If other, please give details

25. Were you wearing a properly adjusted and fastened seatbelt or helmet? Yes ☐ No ☐ Not applicable ☐

26. Did you have any drugs, including prescription drugs, alcohol or illicit drugs, in the 12 hours before the accident?
Yes ☐ If yes, please give details No ☐

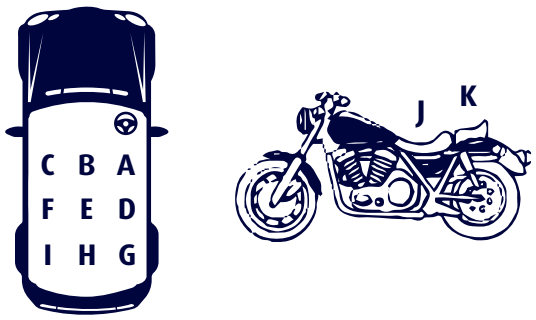
27. Did you have a breathalyser test? Yes ☐ No ☐ Unknown ☐
If yes, please provide result

28. Did you have a drug test? Yes ☐ No ☐ Unknown ☐
If yes, please provide result

29. Did you have a blood sample taken?
Yes ☐ If yes, please provide result and name of hospital where sample was taken No ☐ Unknown ☐

30. If you were a passenger in or on a vehicle, had the driver or rider had any drugs, including prescription drugs, alcohol or illicit drugs, in the 12 hours before the accident?
Yes ☐ If yes, please give details No ☐ Unknown ☐
Not applicable ☐

31. Only if you were in or on a vehicle, mark your seating position on the diagram with an X, and mark other occupants with an O.
Use the provided blank space to draw your own vehicle if required.

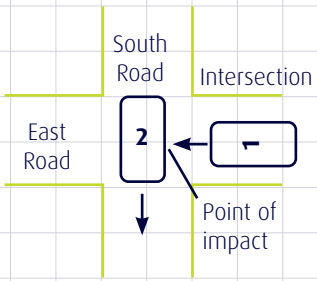


Please continue on page 10 or attach additional page(s) if required.

32. Describe how the accident happened, who caused it, why they are at fault and details of vehicle damage.

33. Draw a picture of the accident scene, including where the point of impact was. If you were in a vehicle mark it by circling it. Number the vehicles as shown in the example. Vehicle 1 should be the vehicle considered most responsible for causing the accident.

Example diagram



Please continue on page 10 or attach additional page(s) if required.

Vehicle

34. **At-fault vehicle**
(considered most responsible for causing the accident)

Plate number | State

If you do not know the plate number of the at-fault vehicle, give as much detail as you can.

Make and model of vehicle (e.g. Toyota Corolla)

Year of manufacture | Body type (e.g. Sedan) | Colour

Driver family name

Driver given name(s)

Driver home address

Postcode | Best contact phone number for driver

Email

Other vehicle

Plate number | State

(please give details of any other vehicles involved in the accident on page 10 or attach additional page(s) if required)

Make and model of vehicle (e.g. Toyota Corolla)

Year of manufacture | Body type (e.g. Sedan) | Colour

Driver family name

Driver given name(s)

Driver home address

Postcode | Best contact phone number for driver

Email

35. Which vehicle were you travelling in or on?

At-fault vehicle ☐ Other vehicle (please give plate number) ☐ I was not travelling in or on a vehicle ☐

Witness

36. Did anyone witness the accident? Yes ☐ If yes, please give details No ☐ Unknown ☐

Witness 1

Family name

Given name(s)

Home address

Postcode | Best contact phone number

Email

Witness 2

Family name

Given name(s)

Home address

Postcode | Best contact phone number

Email

Police report

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

38. Did you report your injuries and accident to the police?

Yes ☐ No ☐

If yes, please detail at which police station you reported

39. Do you have a vehicle collision report number?

Yes ☐ No ☐

If yes, please detail the vehicle collision report number

40. Is police action going to be taken against you? (e.g. traffic infringement notices for speeding) Yes ☐ No ☐ Unknown ☐

Please continue on page 10 or attach additional page(s) if required.

Injuries and treatment

41. Did an ambulance treat you at the accident?
Yes ☐ No ☐

42. Did an ambulance take you from the accident?
Yes ☐ No ☐

43. Were you treated for your injuries at a hospital?
Yes ☐ If yes, name of hospital No ☐

Date attended

Date discharged

44. What are your injuries from the accident?

45. Have you been treated for your injuries since the accident?
Yes ☐ If yes, please give details below No ☐

Treatment	Name of person treating you	Phone number	Date first seen	Are you still receiving treatment? Yes / No

46. How long do you expect your treatment to continue? *If not still receiving treatment, please go to question 47.*

☐ Up to 6 weeks ☐ 6 to 12 weeks ☐ More than 12 weeks ☐ Unknown

47. How do the injuries affect your usual (non-work related) activities now? (e.g. home duties, gardening, family activities)

48. Have you had any injuries or illnesses, before or after this accident, **to the same or similar part(s) of your body** injured in the accident?

Yes ☐ If yes, please give details including approximate date No ☐

49. Are you aware of any **other** previous medical history, health issues or injuries that may affect your recovery from the injury caused by this accident?

Yes ☐ If yes, please give details No ☐

50. Have you made a compensation claim for another personal injury, before or after this accident?
(e.g. assault, medical negligence, workers compensation or another vehicle accident)

Yes ☐ If yes, please give details No ☐

Please continue on page 10 or attach additional page(s) if required.

Employment and income

51. What was your employment status at the time of the accident? *If a student and working part-time, select "employed"*

Employed ☐ Self-employed ☐ Home duties ☐ Not employed ☐ Other ☐ If other, please give details

If not employed, please go to question 61

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

Working hours	Overtime	Gross (before tax) pay	Net (after tax) pay

53. Your occupation

Name of business or employer

Business address

Postcode

Contact person

Contact person details (e.g. phone number and/or email)

Describe your duties *(main work tasks and physical nature e.g. sitting, standing, indoors, outdoors, heavy or light manual work)*

54. Have your injuries prevented you from working in your normal duties? Yes ☐ If yes, please give details No ☐

55. Date you stopped work or your normal duties changed due to your injuries

56. Have you returned to work?
Yes ☐ If yes, date you returned to work No ☐

57. Have you returned to your pre-accident duties?
Yes ☐ No ☐ If no, please give details

58. Have you returned to your pre-accident hours?
Yes ☐ No ☐ If no, please give details

59. Did the accident happen while working? Yes ☐ No ☐

60. Are you claiming for lost income? Yes ☐ If yes, please give details No ☐

Please attach evidence of loss of income or earning capacity (e.g. payslips) to this claim form

61. Are you receiving any Centrelink benefits? Yes ☐ If yes, please give details No ☐

62. Are you receiving or have you received any type of benefit or other compensation related or unrelated to your accident?
Yes ☐ If yes, please indicate below No ☐

☐ Workers compensation (name of insurer)

☐ Private/employer funded income protection (name of insurer)

☐ Other (details)

Please continue on page 10 or attach additional page(s) if required.

Expenses

63. Do you already have expenses relating to this accident to be reimbursed? (e.g. GP visits, specialist consults, physiotherapy or chiropractic, as well as the cost of medications)

Yes ☐ If yes, please attach all receipts you have to this claim form No ☐

64. Do you think you will have any treatment or other claim-related expenses in the future?

Yes ☐ If yes, please give details No ☐ Unknown ☐

65. Any payments from the insurer will be deposited into your nominated account.
You will receive a cheque by post if account details are not given.

Name of financial institution

Bank account number

BSB number

Account held in the name(s) of

Additional information

Page to be used if giving additional information.
Please include question number(s).

Please attach extra pages if required.

Your privacy

If you make a CTP claim, the law requires you must sign the statement below that gives authority to the CTP Insurer managing your claim to collect information relevant to processing and assessing your claim.

The CTP Insurer is required to take reasonable steps to inform you when and why they are using this authority, and they must provide you with a copy of the collected information within 21 days of receipt.

Your personal information may be disclosed between the CTP Insurer, the CTP Regulator, the Nominal Defendant, other state and commonwealth government agencies (such as Lifetime Support Authority, the National Disability Insurance Agency, Centrelink and Medicare), third parties involved in the assessment of your claim (including those described in the statement below), and as otherwise authorised or required by law.

By lodging this form, you consent to your personal information being collected and handled for the purposes above, in accordance with the *Motor Vehicles Act 1959* (SA), the *Compulsory Third Party Insurance Regulation Act 2016* (SA), this privacy statement and as otherwise authorised or required by law. Your consent also covers the collection of personal information (including sensitive information) from you, from the third parties described in the statement below, and as otherwise required or authorised by law.

Statement giving authority to obtain information

The injured person should complete the authority unless they are under 18 years of age or unable to sign the authority. In this case a parent, guardian or Power of Attorney of the injured person should complete the authority.

By completing this authority to obtain information you are giving the CTP Insurer managing your claim permission to obtain documentary information relevant to processing and assessing your claim.

You can seek advice, at your own expense, before signing this authority.

Claimant full name

claimant date of birth

authorises the CTP Insurer managing the claim to obtain documentary information relevant to the claim for damages or other compensation sustained on the date of

from the following people/organisations:

(a) insurers that provide:
- (i) compulsory third party insurance
- (ii) private health insurance
- (iii) motor vehicle insurance
- (iv) workers compensation insurance

(b) health practitioners

(c) hospitals

(d) ambulance or other emergency services

(e) professional providers of rehabilitation services or persons professionally qualified to assess cognitive, functional or vocational capacity

(f) educational institutions

(g) claimant's employer or previous employer

(h) departments, agencies or instrumentalities of the Commonwealth, the State or another State, administering laws about health, police, transport, taxation or social welfare

(i) Lifetime Support Authority of South Australia

(j) ReturnToWorkSA

I approve a copy of this authority, including an electronic copy, can be treated as the original.

This authority is valid for the duration of the claim. CTP Insurer access to information under this authority is subject to requirements detailed in Regulator Rules.

☐ I am signing as claimant ☐ I am signing as parent ☐ I am signing as legal guardian/Power of Attorney

Signature	Date	Name (if not claimant)

Declaration

The injured person should complete the declaration unless they are under 18 years of age or unable to make the declaration. In this case a parent, guardian or Power of Attorney of the injured person should complete the declaration.

Please read the declaration carefully before signing. Under Section 124(6a) of the *Motor Vehicles Act 1959*, you can be fined up to $50,000 or be imprisoned for up to one year for knowingly providing false or misleading information.

I *(full name)*

Best contact phone number

Email

declare that, to the best of my knowledge, the information given in this claim form is true and correct in every respect.

☐ I am signing as claimant

☐ I am signing as parent

☐ I am signing as legal guardian/Power of Attorney

Signature

Date

Nominate an authorised contact

The injured person should complete this section if they decide to nominate an authorised contact to communicate on their behalf with the CTP Insurer managing their claim.

As this nomination will extend to discussing relevant private matters, and supplying and receiving verbal and written information, it is important to nominate an appropriate person.

I agree to the CTP Insurer managing my claim to communicate directly with my authorised contact. This nomination will remain in force until withdrawn by me in writing.

Authorised contact details

Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other ☐ If other, please give title

Family name

Given name(s)

Postal address

Postcode

Best contact phone number

Email

I am nominating a:

☐ Parent (if injured person is under 18)

☐ Legal guardian/Power of Attorney

☐ 'Adult responsible' (guardian, relative, spouse, domestic partner or an adult friend with a close and continuing relationship with the injured person who has an impairment)

Signature

Date

What happens next?

Once the CTP Insurer receives your claim form they will issue a claim number.

You will be allocated a claims consultant who will manage your claim. They will call you (and other people involved in the accident) and send you a confirmation letter. They will also discuss any reasonable and necessary treatment you require. Your treatment may start before liability has been determined.

Information about key stages of the claims process, including fact sheets about lodging your claim, determining liability and settling your claim, is available from the CTP Insurer or the CTP Regulator's website **www.ctp.sa.gov.au**.

CTP INSURANCE REGULATOR

Government of South Australia

Please print this medical certificate and take it to your doctor for completion. Make a copy and provide the completed certificate with your claim form.

This medical certificate must be completed by your treating doctor.

CTP Insurance Claims Medical Certificate

Patient family name / given name(s)

Date of birth | I examined you on: | for injury you stated occurred on:

Is the patient an existing patient of yours, or your medical practice, as at the date of the accident?

Yes, since ☐ No ☐

Motor accident details:

My clinical diagnosis(es) based on my examination of you and other information is:

Is this a: new injury ☐ exacerbation of a pre-existing injury or condition ☐ OR both ☐

Are the injuries consistent with the accident details: Yes ☐ No ☐ If no, give details

Functional ability: Your functional ability is affected by this injury(s)/condition(s) as follows:

Physical function	Can	With modification	Cannot	Mental health	Not affected	Partially affected	Affected
Sitting:	☐	☐	☐	Attention/ concentration:	☐	☐	☐
Standing/walking:	☐	☐	☐				
Keyboard/typing:	☐	☐	☐	Memory (short term and/or long term):	☐	☐	☐
Carrying/holding/lifting:	☐	☐	☐				
Reaching above shoulder:	☐	☐	☐	Judgement (ability to make decisions):	☐	☐	☐
Bending:	☐	☐	☐				
Use of affected body part:	☐	☐	☐	Other comments:			
Neck movement:	☐	☐	☐				
Climbing steps/stairs/ladders:	☐	☐	☐				
Driving:	☐	☐	☐				

Certification: In my opinion, you (please tick whichever apply)

☐ Have recovered from your injury and are fit to return to normal duties and hours on:

☐ Are fit to perform suitable duties that accommodate your functional abilities from: to

☐ Are medically unfit to undertake suitable duties for the period: to

I would like to review your progress on:

Treatment likely to be required:

☐ NIL ☐ Short term (<6 weeks) ☐ Medium term (6-12 weeks) ☐ Long term (>12 weeks)

Proposed treatment and investigation plan: The following plan is aimed at assisting your recovery:

Treatment / investigation	Details of provider	Duration likely required
Radiologist / imaging		
Therapy – physical		
Medical specialist		
Therapy – psych.		
Other		

I have prescribed medication(s) as a result of the accident Yes ☐ No ☐

Prescription details:

Medical practitioner details

Medical practitioner's name

AHPRA Registration number

Email address

Phone / Fax

Name of medical practice or hospital

Address

Postcode

I declare that I am a registered medical practitioner and I physically examined this patient. To the best of my knowledge the information provided here is true and correct

Professional qualification

Signature

Date

Fee schedule: Certificate completion can be charged under the Medicare Benefits Schedule: item number 00023, 00036, or 00044.