MAIC Motor Accident Insurance Commission

QUEENSLAND COMPULSORY THIRD PARTY (CTP) INSURANCE

Notice of Accident Claim Form (Fatal Injury)

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. If you are making a dependency claim, both Parts A and B must be completed.
- The statements contained in this Notice of Accident Claim Form (Fatal Injury), including attachments, must be true to the best of your knowledge. 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 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 a police accident report reference number.
☐ You have identified the insurer of the at-fault motor vehicle.
☐ 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 PART A of this form in the presence of a person over the age of 18 years and to whom you are known.
☐ You have signed PART B of this form in the presence of an eligible witness.
☐ You have attached a certified copy of the death certificate.
☐ You have attached a copy of your marriage certificate (if applicable).
☐ You have attached a certified colour identity document (only if you are completing PART A and PART B).
☐ You have kept all receipts 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 (only if you are completing PART A and PART B).
☐ You have sent your completed form to the CTP insurer of the motor vehicle at fault. To find the relevant insurer, see page 2.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

1. What you need to do

Police reporting

- The motor vehicle accident must be reported to a police officer before lodging a claim for funeral and other expenses and/or dependency. When completing this claim form you will require 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 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 you are only making a claim for funeral and other expenses, then you only need to complete Part A of 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 9 at the end of Part A. Your signing is to be witnessed by a person over 18 years of age, who knows you.
- If you are making a claim for dependency, you must complete both Part A and B. 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. You are also then required to check the box at the bottom of every page where indicated.
- 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 CTP insurer as soon as possible. Your claim could be rejected if the insurer receives it more than nine (9) months after the date of accident.
- **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.
- **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.
- **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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

Part A: Funeral and other expenses

2. Claimant

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

What was your relationship to the deceased?

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

3. Deceased

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

Former home address (include unit number (if applicable), street number and street name) | Street type

Suburb/town | State | Postcode

Has a death certificate been signed? ☐ No ☐ Yes ▶ If yes, attach a certified copy to this form | Date of death (DD/MM/YYYY) | Time of death (HH:MM) ☐ AM ☐ PM

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

4. 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 the deceased's role in the accident?

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

☐ Other, please specify:

If the deceased's role required the use of a seatbelt or helmet, was it being worn? ☐ Yes ☐ No

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

Vehicle registration number

State

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

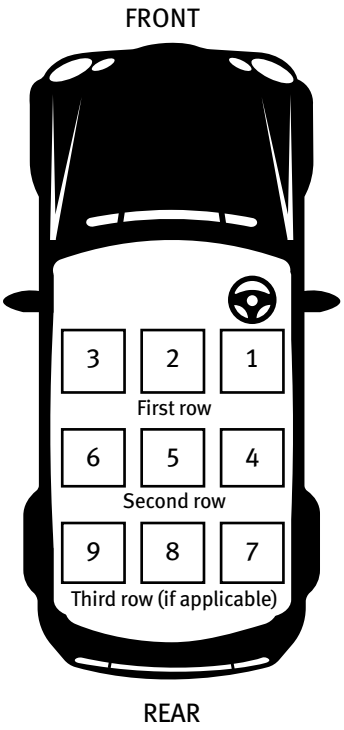
Alcohol ☐ Don't know ☐ No ☐ Yes ▶ If yes Type Quantity

Drugs ☐ Don't know ☐ No ☐ Yes ▶ If yes Type Quantity

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

If the deceased was in a car, utility or truck, mark their 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?



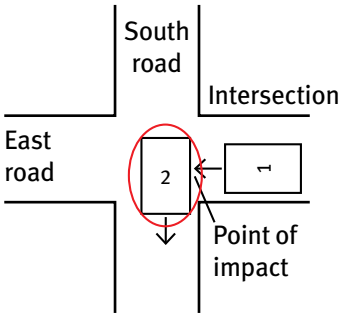
If you provide false or misleading information in relation to your claim, you may be prosecuted.

☐ 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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

Draw a diagram to assist your description. Mark the vehicle the deceased was in (if applicable) by circling it. 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 the deceased was 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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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.

5. 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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

6. 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

7. Hospital

Was the deceased transported to a hospital? ☐ Yes ☐ No ☐ Don't know

Name of hospital

Hospital address

	Street type	
Suburb/town	State	Postcode

Was the deceased, prior to death, admitted to hospital? ☐ Yes ☐ No ☐ Don't know

▶ If yes, was the hospitalisation longer than 24 hours? ☐ Yes ☐ No ☐ Don't know

8. 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

9. Funeral and other costs

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 to finalise your claim. If no, please advise the reason in the box below.

Funeral costs $

Other costs $

Total $

Please attach any receipts, documents, reports or other evidence to support your claim.

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

10. Declaration and authorisation – if completing Part A only

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

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 *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 claimant, an agent of the claimant (e.g. a parent, guardian, relative or friend if the claimant is under the age of 18 or under a legal incapacity) or a substitute signatory (if the claimant/agent 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 claimant's written permission to allow the insurer to obtain records or information that may affect their 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 (Note: an insurer includes a reinsurer and/or overseas insurer)
- 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

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

I have read and understand the contents of this form, 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

Surname/family name

Given name/s

Date of birth / / DD/MM/YYYY

Date of accident / / DD/MM/YYYY

± Signature of agent (if claimant unable to sign)

Date / / DD/MM/YYYY

Signature of witness

I am over the age of 18 years and certify that the claimant/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

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

± Agent of claimant – if another person signs on behalf of the claimant

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 claimant

Details of claimant's legal incapacity

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

Part B: Dependency

1. Claim history

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

2. Have you (or the deceased) ever sustained a significant disability*? ☐ Yes ☐ No

3. In respect of a significant disability*, have you (or the deceased) ever:

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

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

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

2. Relationship

4. What was your relationship to the deceased?

☐ Spouse (including de facto partner) ▶ **Go to section "3. Spouse (including de facto partner)"**

☐ Dependant (e.g. child, parent, grandparent or executor of the deceased's estate) ▶ **Go to section "5. Other dependants"**

3. Spouse (including de facto partner)

5. Details of marriage *(if applicable)*

Date of marriage

/ /

DD/MM/YYYY

Place of marriage

A copy of your marriage certificate must be lodged with this form.

6. Details of de facto relationship *(if applicable)*

Date your defacto relationship commenced

/ /

DD/MM/YYYY

Details of evidence establishing the de facto relationship (e.g. details of a property lease, property ownership, joint bank account)

Copies of evidence establishing the de facto relationship must be lodged with 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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

4. Employment

7. Are you currently employed? ☐ Yes ☐ No

Your occupation

Your employment status

☐ Full time ☐ Part time ☐ Casual ☐ Other:

Employed

Name of employer

Address of employer

	Street type	
Suburb/town	State	Postcode

Self-employed

Name of business

Address (workplace)

	Street type	
Suburb/town	State	Postcode

8. If not employed or self-employed, what was your employment status?

☐ Seeking work ☐ Child ☐ Student ☐ Retired ☐ Home duties ☐ Not employed (health reasons)
☐ Other:

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

10. Weekly gross (before tax) income

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

11. Have you any current health problems?

▶ If yes, give details ☐ Yes ☐ No

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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

13. Is there (or will there be) a workers' compensation, superannuation, life insurance or any other type of claim as a result of the accident? ☐ Yes ☐ No

▶ If yes, name of insurer

Claim number

Policy number

5. Other dependants

14. Details of the other dependant persons.

Complete the following details for all dependant children and other dependant persons (excluding the surviving spouse/de facto partner).

Dependant 1

Title | Surname/family name | Given name/s

Relationship to the deceased | Date of birth (DD/MM/YYYY) | Full-time student ☐ Yes ☐ No

Marital status ☐ Single ☐ Married ☐ De facto | Gender

Best contact number ( ) | Email address

Does the dependant have any separate source of income? ☐ No ☐ Yes ▶ Nature of income

Weekly gross (before tax) income $ | Does the dependant reside with the claimant? ☐ Yes ☐ No

Dependant 2

Title | Surname/family name | Given name/s

Relationship to the deceased | Date of birth (DD/MM/YYYY) | Full-time student ☐ Yes ☐ No

Marital status ☐ Single ☐ Married ☐ De facto | Gender

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of income

Weekly gross (before tax) income

$

Does the dependant reside with the claimant?

☐ Yes ☐ No

Dependant 3

Title

Surname/family name

Given name/s

Relationship to the deceased

Date of birth / / DD/MM/YYYY

Full-time student ☐ Yes ☐ No

Marital status ☐ Single ☐ Married ☐ De facto

Gender

Best contact number

( )

Email address

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of income

Weekly gross (before tax) income

$

Does the dependant reside with the claimant?

☐ Yes ☐ No

Dependant 4

Title

Surname/family name

Given name/s

Relationship to the deceased

Date of birth / / DD/MM/YYYY

Full-time student ☐ Yes ☐ No

Marital status ☐ Single ☐ Married ☐ De facto

Gender

Best contact number

( )

Email address

Does the dependant have any separate source of income?

☐ No ☐ Yes ▶ Nature of income

Weekly gross (before tax) income

$

Does the dependant reside with the claimant?

☐ Yes ☐ No

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

15. Do any of the dependants have any current health problems? ☐ Yes ☐ No

▶ If yes, provide full details, including name of dependant and the nature of the health problem.

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

16. What were the average weekly payments and/or other financial benefits provided to each of the above named dependants by the decreased prior to the accident?

Name of dependant	Average weekly payment/benefit
	$
	$
	$
	$
	$
	$

17. Have you or any of the dependants applied for or received any money or benefit arising out of the accident? (e.g. social security benefits, workers' compensation, borrowed money or insurance payment) ☐ Yes ☐ No

▷ If yes, give details (including amounts):
- If a social security benefit was received, give the social security reference number;
- If workers' compensation, give the insurer's name and claim number;
- If money was borrowed, give the lender's name and address;
- If payment from an insurer was received, give the name and address of the insurer and the claims details.

6. Additional details

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

▶ If yes, against who?

Surname/family name

Given name/s

What role did this person have in the accident?

What is the police action?

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

19. Was there an unidentified vehicle involved? ☐ Yes ☐ No ☐ Don't know

▶ If yes, advise any information that will assist in its identification (e.g., colour of vehicle, unusual features, signwriting). Provide details of how you have tried to identify the vehicle (e.g. contacting or advertising for witnesses)

7. Medical details of deceased

20. Who was the deceased's usual treating General Practitioner (GP)?

GP's name

Practice name

GP address

	Street type	
Suburb/town	State	Postcode

Best contact number ( )

Email

If the deceased had more than one GP, please provide the details on the additional information page/s at the back of this form.

21. Had the deceased suffered any personal injury, illness or disability before or after the accident that may affect the claim in any way? ☐ Yes ☐ No

▶ If yes, please provide details of the injury, illness and/or disability

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

8. Employment details of deceased

22. What was the deceased's employment status as at the date of the accident?

☐ Employed	☐ Self-employed	☐ Unemployed	☐ Retired
☐ Home duties	☐ Student	☐ Other:	

23. Was the deceased employed as at the date of the accident? ☐ Yes ☐ No

▶ **If yes, employment details**

Name of employer (company or organisation)

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Usual weekly working hours

Ordinary Overtime

Usual net (after tax) weekly income

$

Description of duties

24. Was the deceased self-employed as at the date of the accident? ☐ Yes ☐ No

▶ **If yes, employment details**

Name of business

Nature of business

Address (workplace)

	Street type	
Suburb/town	State	Postcode

▶ **If yes, accountant details**

Name of firm

Accountant's name

Address

	Street type	
Suburb/town	State	Postcode

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

25. Did the deceased have a second paid job as at the date of the accident? ☐ Yes ☐ No

▶ **If yes, employment details – second job**

Name of employer

Address (workplace)

	Street type	
Suburb/town	State	Postcode

Usual weekly working hours

Ordinary | Overtime

Usual gross (before tax) weekly income

$

Description of duties

26. Did the deceased have any other source of income? ☐ Yes ☐ No

▶ If yes, nature of separate source of income

Usual gross (before tax) weekly income

$

27. List the particulars of the deceased's employment during the **three** years prior to the accident *(if applicable)*

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

List the particulars of the deceased's self-employment during the **three** years prior to the accident *(if applicable)*

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

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

28. Before the accident, had the deceased made any firm arrangements to start a new job, stop work, change duties, working hours or earnings? ☐ Yes ☐ No

▶ If yes, give details

9. Payment to you/offer of settlement

29. 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, reports, photographs or other evidence to support your claim.

10. Identification

This section only applies to the person whose details are under section "2. Claimant" on page 3 of this form.

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

11. Declaration and authorisation

This declaration and authorisation requires completion when you complete 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 signed 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**.

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 claimant, an agent of the claimant (e.g. a parent, guardian, relative or friend if the claimant is under the age of 18 or under a legal incapacity) or a substitute signatory (if the claimant/agent 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 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, 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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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: ☐ **Claimant or** ☐ **Agent of claimant or** ☐ **Substitute signatory**

Date

/ /

DD/MM/YYYY

If signing as substitute signatory*:

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

Surname/ family name of claimant

Given name/s of claimant

Date of birth of claimant

/ /

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 claimant** (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 claimant

Reason why the claimant cannot sign

± **Details of substitute signatory** (if applicable)

Surname/family name of substitute signatory

Given name/s of substitute signatory

Relationship to the claimant/agent

Reason why the claimant/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 your signature, please visit maic.qld.gov.au/witness-signing-fact-sheet.**

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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.**

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.

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.

© Motor Accident Insurance Commission 2022. Reproduction prohibited, other than saving this form electronically, printing or photocopying it for the purpose of making a claim.