Driver Protection Cover claim form

This form must be lodged within 12 months of the accident date. Complete this form if the at-fault driver was driving a vehicle with NRMA CTP Insurance and sustained any injuries listed in question 5 or died as a result of the motor vehicle accident.

Use block letters and print clearly

1. The details of the person driving the at-fault vehicle

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Other

Surname

First name(s)

Postal address

State

Postcode

Home telephone number

Work telephone number

Mobile number

Email Address

2. The NRMA Insurance CTP Policy number for the at-fault vehicle

CTP Policy Number

3. The details of the vehicle at-fault in the accident

Registration number

State

Year of manufacture

Make

Model

Body type

☐ Sedan ☐ Coupe ☐ Hatchback ☐ Station wagon ☐ Ute ☐ Van Other

4. The details of the NRMA Insurance policy holder

If the person named in question 1 is also the policy holder, write 'as above'

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Other

Surname

First name(s)

Postal address

State

Postcode

Home telephone number

Work telephone number

Mobile number

Email Address

5. Indicate what cover is being claimed under the at-fault driver cover

Tick all that may apply. Please provide supporting information, including hospital discharge summary and/or imaging reports.

- [ ] Quadriplegia
- [ ] Paraplegia
- [ ] Loss of both hands and both feet
- [ ] Loss of both hands or both feet
- [ ] Loss of one hand and one foot
- [ ] Loss of one hand or one foot
- [ ] Loss of thumb and forefinger on one hand
- [ ] Total loss of sight in both eyes
- [ ] Total loss of sight in one eye
- [ ] Total loss of speech
- [ ] Total loss of hearing
- [ ] Third degree burns to more than 10% of body
- [ ] Displaced fracture to pelvis
- [ ] Displaced fracture to skull
- [ ] Displaced fracture to spinal vertebrae
- [ ] Death

6. The licence details of the driver mentioned in question 1

Licence number | Licence expiry date | Years of driving

Date of birth | Age in years

7. What kind of licence did the driver named in question 1 have at the time of the accident?

- [ ] Learner's licence ▶ Go to **8**
- [ ] Provisional licence ▶ Go to **9**
- [ ] Other driver's licence ▶ Go to **9**

8. Did the 'Learner' driver have a licenced driver supervising them at the time of the accident?

- [ ] No ▶ Go to **9**
- [ ] Yes

The licenced driver's name | Licence number | Licence expiry date

The licenced driver's address

State | Postcode

9. Accident details

Date of accident | Time of accident | [ ] am [ ] pm

Where did the accident happen?

State | Postcode

Nearest cross street or other reference point which will help us identify the location

10. Provide a detailed description of the accident

11. Sketch a diagram of the accident

- Mark the at-fault vehicle with an 'A'.
- Number any other vehicle as 1,2,3 etc.
- Show all vehicles and other property involved.
- Show which way the at-fault vehicle was travelling.

If more space is required to describe or sketch the accident details please attach a separate sheet

12. Did a police officer attend the accident?

☐ No ▶ Go to **13** ☐ Yes

Police officer's name | What is the police event number? | Station the police officer came from?

13. Has the accident been reported to police?

☐ No ▶ The accident must be reported before a claim can be made ☐ Yes

Date reported

Police officer's name | What is the police event number? | Station the police officer came from?

14. Was the driver named in question 1 breathalysed?

☐ No ▶ Go to **15**

☐ Yes – what was the result? ☐ Above the legal limit ☐ At or below the legal limit

15. Did the driver named in question 1 take any drugs or alcohol in the 24 hours before the accident?

☐ No ▶ Go to **16** ☐ Yes

What had they taken?

When and how much?

16. Was the driver named in question 1 asked to have a blood or drug test?

☐ No ▶ Go to **17**

☐ Yes – did the driver agree to be tested? ☐ No ▶ Go to **17**

☐ Yes – What was the reading

17. Were any vehicles, other than the vehicle mentioned in question 3, involved in the accident?

☐ No ▶ Go to **18**

☐ Yes – How many?

18. Are details available for the other vehicles involved in the accident?

☐ No ▶ Go to **19** ☐ Yes – Please give details

Vehicle 1: Owner's name and contact details | Registration number | State

Vehicle 2: Owner's name and contact details | Registration number | State

If more than two other vehicles were involved in the accident, please attach a separate sheet with the above details.

19. Please list all treatment and medical practitioners that the driver named in question 1 has seen for treatment of their injuries arising from the accident.

Name of practitioner

Address (practice or surgery)

State | Postcode

Name of practitioner

Address (practice or surgery)

State | Postcode

Name of practitioner

Address (practice or surgery)

State | Postcode

20. Is the driver in named in question 1 entitled to any kind of personal injury compensation payment or damages? Please also advise if a prior payment has been made arising from this accident.

☐ No ▶ Go to **21** ☐ Yes – Please give details

21. Has the driver named in question 1 been admitted as either an interim or permanent participant in the NSW or ACT Lifetime Care and Support Scheme?

☐ No ▶ Go to **22**

☐ Yes ☐ Permanent Participant ☐ Interim Participant

22. If death cover is claimed please provide the name and contact details of the Executor of the deceased estate.

Name of Executor

Contact telephone number

Address

State

Postcode

Declarations

Insured's declaration (to be signed by the person named in question 4).

The statements made in this claim form by me/us, or on my/our behalf, are, to the best of my/our knowledge, truthful and frank. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is inaccurate or concealed.

I/We authorise NRMA Insurance to give to, or obtain from, other insurers or any insurance reference bureau any information relating to:

- this claim
- any claim made by me/us, or
- any insurance held by me/us.

Signature of insured

Date signed

Driver's declaration (to be signed by the person named in question 1 or their representative).

The driver must complete and sign this declaration even if they are the insured and have signed the declaration above. The information and answers given above are, to the best of my knowledge, truthful and frank. No information likely to affect this claim has been withheld. I understand that this claim may be refused if information is untrue, inaccurate or concealed.

I authorise NRMA Insurance to give to, or obtain from, other insurers or any insurance reference bureau any information relating to:

- this claim
- any claim made by me, or
- any insurance held by me.

I authorise NRMA Insurance to contact and obtain information and documents in relation to this claim from:

- any doctor, ambulance service, hospital or other service provider
- my employer
- my accountant
- any Police department
- The Lifetime Care and Support Authority of New South Wales
- The State Insurance Regulatory Authority of New South Wales.

Signature of driver (or their representative)

Name of driver (or their representative)

Date signed

Collection, Use and Disclosure of Your Personal Information

We are committed to handling your personal information in accordance with our Privacy Policy.

Collection, use and disclosure of your personal information.

We need to collect, use and disclose your personal information in order to investigate, assess and pay your claim. You can choose not to provide us with the information requested but this may affect our ability to do these things.

By providing your personal information to us you acknowledge and consent that:

- **we can collect and use your personal information for the following purpose:** to investigate, assess and pay your current and any subsequent claim; and to underwrite and price any policy issued by us or our related entities
- **for these purposes we can collect your personal information from, and disclose it on a confidential basis to the following:** your employer, our insured, our related entities, our distributors and agents, other insurers, government department and agencies, law enforcement agencies, investigators, lawyers, medical providers, advisers and the agent of any of these
- **you represent to us:** that where you provide personal information to us about another person, you are authorised to provide that information to us and you will inform that person who we are, how we use and disclose their information and they can gain access to that information (unless doing so would pose a serious threat to the life or health of any individual).

Our Privacy Policy

Further information on how we handle your personal information, including how to access your information, is explained in our Privacy Policy. A copy of our Privacy Policy is available at any NRMA Office or at nrma.com.au/privacy

I have read the 'Collection, use and disclosure of personal information' section of this form and I consent to NRMA Insurance handling my personal information in the manner described.

Signature of driver (or their representative)

Name of driver (or their representative)

Date signed

What to do with this claim form

Please return this claim form by mail to:

NRMA Insurance
Compulsory Third Party Department
GPO Box 481
Sydney NSW 2001

Claims enquiries

For any enquiries about your claim, you can phone **1800 032 220**

from anywhere in Australia, 9am to 5pm Monday to Friday.

Medical Certificate

This medical certificate must be completed by a medical practitioner, provided as part of the claim form and should only be completed when an at-fault driver is claiming a benefit under the NRMA Insurance Driver Protection Cover.

Use block letters and print clearly

1. What are the details of the patient?

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Other ____

Surname ____ First name(s) ____

Date of motor vehicle accident ____ Date of birth ____ Date of examination ____

2. Did the patient sustain any injuries in the motor vehicle accident?

☐ No ▶ Go to **4** ☐ Yes – Indicate which injuries below:

☐ Quadriplegia
☐ Paraplegia
☐ Loss of both hands and both feet
☐ Loss of both hands or both feet
☐ Loss of one hand and one foot
☐ Loss of one hand or one foot
☐ Loss of thumb and forefinger on one hand
☐ Total loss of sight in both eyes
☐ Total loss of sight in one eye
☐ Total loss of speech
☐ Total loss of hearing
☐ Third degree burns to more than 10% of body
☐ Displaced fracture to pelvis
☐ Displaced fracture to skull
☐ Displaced fracture to spinal vertebrae
☐ Death

3. Does the patient have any pre-existing injuries to the same body parts?

☐ No ☐ Yes

4. Did the patient die as a result of the motor vehicle accident?

☐ No ☐ Yes

5. Did the injuries to, or the death of the patient occur as a direct result of the motor vehicle accident?

☐ No ☐ Yes

Insurance Australia Limited ABN 11 000 016 722 AFS Licence No. 227681 trading as NRMA Insurance.

6. Practice details

Doctor's name

Address (practice or surgery)

State

Postcode

Telephone number

Facsimile number

Area of Speciality

Declaration

Medical practitioner's declaration (to be signed by the registered medical practitioner).

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 of medical practitioner

Name of medical practitioner

Date signed