PERSONAL INJURIES

DEFINED BENEFITS APPLICATION

FOR ACCIDENTS ON OR AFTER 1 FEBRUARY 2020

ACT Government | Motor Accident Injuries Commission

Use this form to apply for medical and income benefits if you've been injured in a motor accident on or after 1 February 2020.

1. Seek medical treatment

Obtain treatment and have your doctor complete the Motor Accident Injuries Medical Report.

2. Notify the police

If police did not attend, report the accident online or at a police station within 24 hours.

3. Complete this application

Complete as much of this form as you can, and gather all required attachments.

4. Submit form to insurer

Send this form with all attachments to the insurer of the at-fault vehicle, or to your MAI insurer if unknown.

Need help? Call 1300 209 642 for the free Defined Benefits Information Service.

Information

- Complete this form and send it to the relevant insurer, as per step 4 above, with the required attachments.
- To find the insurer of an ACT registered vehicle, visit *Access Canberra - Check Registration Details*.
- If you're filling out this form by hand, please use a blue or black pen. Mark boxes like this ☐ with a ✓ or a X.
- Any attachments will form part of this application and the declaration and authorisation will include them.
- If you're acting on behalf of the applicant as a parent, guardian, or a personal representative of a deceased applicant, please complete the section identifying who you are, your relationship to the applicant, and the reason you're acting on their behalf.
- To be assessed as eligible to receive income replacement payments from the date of the motor accident, an application for defined benefits should be made within 13 weeks after the date of accident.
- A late application may be made within 2 years after the date of the accident, accompanied by a full and satisfactory explanation for the delay which satisfies the insurer. Defined benefit income payments may only begin from four weeks before the date the late application is made.

What happens next?

5. The insurer will be in touch with you

Once you have submitted this form, the insurer will be in touch with you to acknowledge receipt, and advise next steps. They may contact you to find out more information to support your application.

6. The insurer will assess your application

The insurer has 28 days from the receipt notice to assess your application. During this time they may ask you additional questions to help them manage your case. You will be eligible for reimbursement for some early medical expenses.

7. If eligible, you will receive defined benefits

If liability is accepted, you may receive income benefits, and the insurer will pay your reasonable and necessary treatment and care expenses.

8. Continue with your treatment

Continue with your treatment, with the support of the insurer. If you are receiving income benefits, your doctor will need to complete the certificate of fitness at regular intervals for the duration of your recovery.

Checklist

- ☐ **Police accident report number or copy of AFP Crash Report.**
- ☐ **Motor Accident Injuries Medical Report completed by your doctor.**
- ☐ **Attach invoices for medical treatment received if you would like to claim for those payments.**
- ☐ **Keep a copy of this form and any attachments such as evidence of medical treatment.**

1. Your details

First name

Middle name(s)

Last name

Date of birth (dd/mm/yyyy)

/ /

Gender

☐ F ☐ M ☐ X

Title

☐ Dr ☐ Mrs ☐ Ms ☐ Mr ☐ Other:

Medicare number and reference number

Drivers licence number (if applicable)

Provide at least one phone number:

Mobile phone number (if applicable)

Home phone number (if applicable)

Work phone number (if applicable)

Email address

Home address (unit, street number, street name, suburb, state, postcode)

Contact preference

☐ Mobile ☐ Email ☐ Home phone ☐ Work phone

If you need an interpreter, please tell us your preferred language.

Payment details

Account name

BSB

Account number

Have you ever made a CTP or MAIS claim for injury from a motor accident?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please provide details below:

Date of injury (dd/mm/yyyy)

/ /

Claim number

Insurer at time of injury

Have you made an application to workers compensation with respect to this motor accident?

☐ No ▶ **If no,** skip to the next question. *(If you make an application to workers compensation, you will need to give the insurer this information).*

☐ Yes ▶ **If yes,** please give the details below:

Workers compensation insurer

Has liability been accepted? ☐ No ☐ Yes

Claim number

State

2. About the accident and your injuries

Please provide details of the motor accident that led to your injury. Provide the **Police Accident Report number** if police attended, or attach a completed **AFP Crash Report** (on-line). Attach any photos or details of witnesses you may have, if available. These documents help us process your application. If you need more space, attach a separate sheet of paper titled *'About the accident'.*

Did police attend?

☐ No ☐ Yes ▶

Police Accident Report or AFP Crash Report number (e.g. P1234567)

You can obtain the report number by calling the Police Assistance Line on 131 444 or by visiting a police station. You can still submit this application in the meantime.

Date of the accident (dd/mm/yyyy) / /

Approximate time of the accident ☐ am ☐ pm *(tick one)*

Where did the accident occur? (e.g. corner, intersection, street, number/name, suburb)

In the accident, you were the:

☐ Driver ☐ Passenger ☐ Motorcyclist ☐ Other (give details):

☐ Cyclist ☐ Pedestrian ☐ Pillion passenger

In your own words, please describe (or draw) the motor vehicle accident you were involved in.

If applicable, were you wearing a seatbelt if you were in a vehicle, or helmet if you were on a bicycle or motorcycle?

☐ Yes ☐ No

Details of all vehicles involved in the accident

Provide as much information as you can, including your own vehicle. Place a tick to indicate the vehicle you believe to be most at fault (if known). If a vehicle that caused the accident is unidentified (e.g. a "hit-and-run accident"), write "unidentified" in the first column. Please also attach a separate document describing the vehicle and any steps you have taken to identify the vehicle (e.g. seeking witnesses).

Registration Number	**State**	**Most at fault**	**Driver's name**	**Driver's contact** (e.g. phone, email)	**Number of passengers**
I'm unsure who's most at fault					

3. About your health

Please attach any evidence of medical treatment you have received as a result of your accident, including invoices and any receipts for any medical expenses incurred, and a completed **Motor Accident Injuries Medical Report**, which you can obtain from your doctor.

On making your application, you can be reimbursed for the following medical expenses:

- up to two consultations with a general practitioner, being no higher than a level B consultation for initial treatment and a further consultation no higher than a level C consultation that is necessary to prepare a medical report; and
- up to two allied health treatments (such as physiotherapy) on referral by a registered medical practitioner, subject to payment caps.

Other medical expenses incurred will be assessed for reimbursement once your application has been accepted.

In your own words, please outline all injuries you received as a result of the motor accident you have described above.

4. Treatment details

Did an ambulance attend the accident:

☐ No ▶ **If no,** skip to the next question.

☐ Ambulance attended the accident, but did not provide me with any treatment.

☐ Ambulance attended and provided me with treatment.

Did you receive treatment at the hospital after the accident?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please give the hospital and ambulance details below (if applicable).

Name of the hospital where you were treated

Were you taken to the hospital in an ambulance?

☐ No ☐ Yes

Have you been discharged from hospital?

☐ No ☐ Yes, I was discharged on / / (dd/mm/yyyy)

Were you suffering an illness or injury affecting the same or similar parts of your body at the time of the accident?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please describe your illness/injury (including the approximate date of injury).

5. About your employment and income information

Complete section 6 and 7 if you would like to claim for lost income due to your motor accident injury. Your insurer will contact you for you to provide your **proof of employment** and **wage information** such as your **pay slips**, an **employment contract**, or your last **PAYG statement(s)**, and any other information they may require with respect to your work and pay arrangements in the 52 weeks prior to the accident.

You may receive interim payments subject to the insurer having enough information to show you were working, such as payslips or a contact for your employer(s).

If you are self-employed, you will need to provide evidence of your earnings, such as your last tax return, business activity statements or a letter from your accountant.

6. Employment details

Have you been away from work as a result of the accident?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please provide dates away from work:

What was your employment status at the time of the accident?

☐ Hours per week ☐ Full-time ☐ Part-time ☐ Casual ☐ Self-employed ☐ Other

What is your usual occupation?

Employer name

Please outline your earnings at the time of the accident
(Please tick the applicable time frame)

$	Weekly	Fortnightly	Monthly	Annually

If you were an employee, this is your gross income before tax and payroll deductions.

7. Employer contact details

If you are self-employed, skip this section and proceed to section 8.

Would you like us to obtain your wages information directly from your employer(s)?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please complete the following:

Employer contact name **Phone number** **Email address**

Contact address (unit, street number, street name, suburb, state, postcode)

If you have more than one employer, attach a separate sheet titled 'Additional Employer Details', to provide a contact name, phone number, email address, contact address, and employment status for each of your employers.

8. About personal information

The insurer will need authority to collect your personal and health information to help manage your application.

Why?

- To assist with your rehabilitation and to assist the insurer to better manage your application.
- For the purpose of enabling the insurer to process, assess and manage your application and to verify any evidence you may submit in support of your application.
- To ensure the application is compliant with ACT motor accident injuries legislation.
- For the purposes of legal proceedings under that legislation if required.

Insurers may need to disclose personal and health information about you to each other and relevant organisations.

Why?

- To process, assess and manage your application.
- To support any complaint or enquiry made by you to any authority.

9. Collection of personal and health information to manage your application

- Personal and health information provided by you may be retained, used and disclosed by:
  - licensed insurers to manage your application and determine your entitlements, and
  - the Motor Accident Insurance Commission as regulator of the MAI scheme under the *Motor Accident Injuries Act 2019* (ACT).
- Any personal and health information you provide will be collected, retained, used and disclosed in accordance with (where relevant) the *Motor Accident Injuries Act 2019* (ACT), *Information Privacy Act 2014* (ACT), *Health Records (Privacy and Access) Act 1997* (ACT), *Freedom of Information Act 2016* (ACT) and the Commonwealth *Privacy Act 1988*.
- Under the *Motor Accident Injuries Act 2019*, the MAI Commission may, despite anything to the contrary in the *Information Privacy Act 2014* or the *Health Records (Privacy and Access) Act 1997*, collect, use and disclose data relating to third party policies, claims, activities and performance of insurers and the provision of health, legal and other services to injured persons.

10. Declaration and authorisation

Please read this declaration carefully before writing your name below and signing.

- All information you have provided in this application form must be true and correct in every respect.
- Under part 3.4 of the *Criminal Code 2002*, you can be fined, imprisoned, or both for either knowingly or recklessly providing false or misleading information in this form, or omitting anything without which the information is false or misleading.
- You give consent and authorise the release of any information in relation to your application to the MAI Commission for the purpose of data analysis to assist in the regulation and improvement of the MAI scheme. This includes consent to be contacted by the MAI Commission or an authorised third party to provide feedback of your experience of the MAI scheme.
- You give consent and authorise the MAI insurer managing your application for defined benefits to:
  - obtain information and documents relevant to the processing and managing of your application from the persons and entities specified in this authorisation below; and
  - provide information and documents relevant to the processing and managing of your application to the persons and entities specified in this authorisation below.
- The relevant information and documents for processing and managing your application may include information and documents about your pre-accident circumstances and prior incidents.

For the purposes of processing and managing your application for defined benefits, the consent and authorisation to release, use, disclose and exchange your personal and health information apply by, to, and between:

- your treating health service provider
- a member of your treating team
- a health practitioner who conducts an assessment of your needs for treatment and care or fitness to work, including a medical or other examination
- an authorised independent medical examiner (IME) and IME provider arranging and conducting your Whole Person Impairment (WPI) assessment (if required)
- an authorised independent medical examiner or independent health assessor and IME provider arranging and conducting your Significant Occupational Impact (SOI) assessment (if required)
- Medicare and Centrelink (Services Australia)
- any police service
- the Coroner's Court of the ACT
- any employer or accountant of the injured person
- any personal injury insurer or workers compensation insurer
- any property damage insurer
- the relevant insurer or another MAI insurer
- the ACT Lifetime Care and Support Scheme
- the ACT MAI Commission
- the ACT Civil and Administrative Tribunal (ACAT)

This consent operates until you either revoke the authority by notice, in writing, to the MAI insurer managing your application for defined benefits, or are no longer entitled to defined benefits in relation to the motor accident. If the authority is still reasonably required to process and manage your application, revocation may result in the suspension of your application.

I, (print name) _____

declare that, to the best of my knowledge, the information given in this form is true and correct. I also give consent and authorisation for the release, use, disclosure and exchange of my personal and health information by, to, and between the persons and entities set out in section 10 of this form for the purposes of processing and managing my application for defined benefits.

Signature

_____

Date (dd/mm/yyyy)

/ /

If you are acting on behalf of the applicant as parent, guardian, or personal legal representative, please complete this section:

Relationship to injured person

_____

Reason injured person cannot sign

_____

Address

_____

Authorised by: **ACT Government | Motor Accident Injuries Commission** Catalogue No. MAIPIA06 05/22