Notice of Claim and Additional Information Forms (NOCAIF)

As prescribed under section 84(2)(a) and sections 88(1)(b) and 88(2)(a) of the
Road Transport (Third-Party Insurance) Act 2008
For Compulsory Third-Party (CTP) Insurance Claims in the
Australian Capital Territory (ACT).

Instructions

- The Notice of Claim and Additional Information Forms (NOCAIF) is the third of three (3) forms to be filled out by the injured party (the Claimant) to a motor vehicle accident:

  1. Motor Accident Notification Form (MANF)
  2. Motor Accident Medical Report (MAMR)
  3. **Notice of Claim and Additional Information Forms (NOCAIF)**

- The Notice of Claim and Additional Information Forms (NOCAIF) contain two (2) parts:

  Part 1—Notice of Claim Form
  Part 2—Additional Information Form

- You are to fill out the **Notice of Claim Form** if you wish to file a claim against your Insurer.
- The Insurer has one (1) month to respond to your **Notice of Claim**.
- You are only required to provide additional information in the **Additional Information Form** if your Insurer requires more information from you to substantiate your claim.
- If you are required to fill out this form by the Insurer, you have one (1) month in which to do so from the date of receiving the Forms.

This form is Approved Form AF2008-127, approved on 12 September 2008 by Tom McDonald, delegate of the chief executive, under section 276 of the *Road Transport (Third-Party Insurance) Act 2008*.
Authorised by the ACT Parliamentary Counsel—also accessible at www.legislation.act.gov.au

Notice of Claim and Additional Information Forms

As prescribed under sections 84(2)(a) and sections 88(1)(b) and 88(2)(a) of the *Road Transport (Third-Party Insurance) Act 2008*.
To be used for Compulsory Third-Party (CTP) Insurance Claims in the Australian Capital Territory (ACT).
These Notice of Claim and Additional Information Forms are to be completed by the Claimant.
For information on the ACT Compulsory Third-Party Scheme visit the
ACT Department of Treasury web site at:
www.treasury.act.gov.au/compulsorytpi/index.shtml

Please complete this form in BLOCK LETTERS

Part 1—Notice of Claim (Section 84(2)(a))

To the Insurer

Address

Postcode

1. Your personal details (being the injured person or "claimant")

1.1 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

1.2 Given Name(s)

1.3 Surname

1.4 Date of Birth / /

1.5 Medicare Number

1.6 Home Address

Postcode

1.7 Postal Address or 'as above' if the same

Postcode

1.8 Home Phone Number ( )

1.9 Work Phone Number ( )

1.10 Mobile Phone Number

1.11 Have you ever been known by another name? (e.g., maiden name)

No ☐

Yes ☐ ► Give details below

1.12 Surname

1.13 Given Name(s)

2. Accident/Incident Details

2.1 Date of Accident / /

2.2 Time of Accident ☐ am ☐ pm

2.3 Place of Accident (include street, town and state)

Postcode

2.4 Do you have the registration number of the vehicle you consider most at fault?

Yes ☐ ► Give details below

No ☐

2.5 Registration Number including state registered in

2.6 Year, Make and Model of Vehicle (if known)

2.7 Colour and body type (if known)

2.8 Name and address of owner (if known)

Postcode

2.9 Home Phone Number ( )

2.10 Work Phone Number ( )

2.11 Name and address of driver (if same person please write 'as above')

Postcode

2.12 Home Phone Number ( )

2.13 Work Phone Number ( )

Claimant's Intention to Proceed

(As prescribed under Section 84(2)(a) of the *Road Transport (Third-Party Insurance) Act 2008* and Part 6, section 20 of the *Road Transport (Third-Party Insurance) Regulation 2008 (Regulation)*)

I/We intend to proceed with this claim against the Respondent in anticipation that all matters under Part 4.2 of the *Road Transport (Third-Party Insurance) Act 2008* have been fully complied with.

Authorisation and Declaration

Protection of Privacy

- The information collected by this Notice of Claim Form, and throughout the course of your claim, is collected in accordance with the *Road Transport (Third-Party Insurance) Act 2008* and *Road Transport (Third-Party Insurance) Regulation 2008* (*Regulation*).
- The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to help the administration of the statutory insurance scheme and the detection of fraud.
- The information collected by this Notice of Claim Form and throughout the course of your claim, may be disclosed in accordance with the *Road Transport (Third-Party Insurance) Act 2008* and *Road Transport (Third-Party Insurance) Regulation 2008* (*Regulation*) to such bodies as, the CTP regulator, the Nominal Defendant, and other insurers or parties involved in the assessment of your claim, such as those indicated below.
- Failure to provide all or part of the information may delay or prevent the assessment of your claim.
- You are able to gain access to personal information held as provided by the *Privacy Act 1988* (Cth), or if the information is held by the Australian Capital Territory Government, you are able to gain access to the information as provided by the road transport legislation.

Authority to obtain information

For the purpose of assessing my claim, I hereby authorise the insurer against whom this claim is made, to contact and obtain information and documents relevant to the claim for personal injury damages, sustained in the accident which occurred on ……../……../…… as follows:-

1. Clinical notes in the possession of a health service provider who treated or assessed me in relation to the personal injury.

2. Medical reports from health service or rehabilitation providers who have treated or assessed me for my injuries, or any pre-existing injury or condition exacerbated by the accident.

3. Clinical notes in the possession of any hospital (including any private hospital) where I received treatment relevant to the personal injury.

4. Records in the possession of an Ambulance or other emergency service that treated or assisted me in relation to the personal injury.

5. Clinical notes in the possession of a health service provider or hospital which treated or assessed me for the pre-existing injury or condition exacerbated by the accident.

6. Wage, leave and work history records in the possession of (i) my employer, (ii) anyone else who employed me at any time during the 3 years before the accident;

   OR (if self-employed)

7. My accountant.

8. Any records concerning me in the possession of an insurer carrying on the business of providing CTP insurance or Workers' Compensation insurance, regarding any previous or concurrent claims, or insurance against the loss of income through disability.

9. Records from any of the following:

   - other licensed insurers;
   - a department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
   - a doctor, professional provider of rehabilitation services or person professionally qualified to assess cognitive, functional or vocational capacity, and
   - an educational institution.

   (Note: An insurer includes a reinsurer and/or overseas reinsurer)

The signing of this Form constitutes my written permission to allow the insurer to obtain records or information that may affect my claim (including information on my pre-accident circumstances). Persons and entities who may be asked to provide information in relation to me are listed above.

I, the claimant (or their agent) signed hereunder, declare I understand this declaration and authorisation.

Signature of Claimant or their Agent		Date of Signing
		/ /

This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant cannot sign because they are a minor or due to injuries sustained etc, this Form must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf of the claimant).

If the claimant is unable to sign as noted in the paragraph above, please provide details of the person who signed (agent of the claimant).

Agent's Surname		Agent's Given Name(s)

Home Phone Number		Work Phone Number		Relationship to the Claimant
( )		( )		

Reason(s) why the Claimant could not sign

Documents which MUST accompany this Notice of Claim

The Notice of Claim must be accompanied by the following documents:

- A copy of any other document, etc. on which the claimant currently expects to rely for the claim that is in the claimant's possession.

Additional Information

Use this space to provide additional information to questions in the form.

Part 2—Additional Information Form (Sections 88(1)(b) and 88(2)(a))

This form will help you if the Insurer requires you to provide additional information.

2.14 Road conditions (e.g., dry, wet, unsealed roads, etc.)

2.15 Weather conditions (e.g., fine, heavy rain, sun, etc.)

2.16 Vehicle details

Vehicle	Estimate of speed	Number of people in vehicle
1	km/h	
2	km/h	
3	km/h	
4	km/h	

2.17 Damage to vehicles

Vehicle	Damage to vehicles
1	
2	
3	
4	

2.18 Names, addresses and telephone numbers of witnesses not listed in the Motor Accident Notification Form

1.

Postcode

2.

Postcode

2.19 Information about unidentified vehicles: include information about colour of vehicle, unusual features, signwriting, etc. In attempting to identify the vehicle, did you talk to witnesses, advertise for witnesses to contact you, or ask the police?

3. Police Action

3.1 Are you aware of any police action arising from the accident?

No ☐

Yes ☐ ▶ Give details

3.2 If yes, what part did this person have in the accident?

3.3 If yes, name of person to be charged

3.4 If yes, reason for action

4. Injury and Rehabilitation

4.1 What injuries did you sustain in the accident? (List all injuries and state all parts of the body that sustained injury).

4.2 How do the injuries affect you now? (e.g., walk with crutches.)

4.3 Did you need an ambulance?

No ☐

Yes ☐ ▶ Give details below

4.3.1 Officer's name and station

4.4 Were you treated at any hospital other than the hospital named in the Motor Accident Notification Form?

No ☐

Yes ☐ ▶ Give details below

4.4.1 Hospital's name, address and date of treatment

4.5 Were you admitted to any hospital other than the hospital named in the Motor Accident Notification Form?

No ☐

Yes ☐ ▶ Give details below

4.5.1 Hospital's name, address and date of admission

4.6 Who has treated you for your injuries? (List all doctors, surgeons, physiotherapists, etc and addresses of surgeries)

1.

Postcode

2.

Postcode

3.

Postcode

4.7 Has rehabilitation been recommended to you?

No ☐

Yes ☐ ▶ Give details below

4.7.1 What rehabilitation has been recommended? (e.g., counselling, exercise program etc.)

4.8 Have you started rehabilitation?

No ☐

Yes ☐ ▶ Give details below

4.8.1 What rehabilitation have you had?

4.9 Who is providing or who is proposed to provide the rehabilitation services?

Postcode

4.10 Do you plan to commence rehabilitation?

No ☐

Yes ☐ ▶ Give details below

4.10.1 What rehabilitation will you commence?

5. Financial Loss

5.1 Have you lost or will you lose wages, salary or business income because of the accident?

No ☐ ▶ Go to 5.16.1

Yes ☐

5.2 Are you still losing income?

No ☐

Yes ☐

5.3 Have you returned to work at all since the accident?

No ☐

Yes ☐ Date:

5.4 If you have not returned to work, do you expect to return to work?

☐

Yes ☐ Date:

5.5 What is your usual occupation?

5.6 List particulars of your employment during the last three (3) years prior to the accident and the period since the accident

Name and address of employer	Capacity in which employed	Period of employment	Income for period

5.6.1Self employed details

Nature of self-employment	Period of self-employment	Gross earnings per year	Net income per year

5.7 How many separate periods of time have you been away from work because of the accident? (Include short periods when you went for treatment)

5.7.1 First period

Work or time lost (weeks, days, hours)	From: (day/month/year)	To: (day/month/year)
• Weeks:		
• Days:		
• Hours:		

5.7.2 Second period (if applicable)

Work or time lost (weeks, days, hours)	From (day/month/year)	To (day/month/year)
• Weeks:		
• Days:		
• Hours:		

5.7.3 Third period (if applicable)

Work or time lost (weeks, days, hours)	From (day/month/year)	To (day/month/year)
• Weeks:		
• Days:		
• Hours:		

5.7.4 Fourth period (if applicable)

Work or time lost (weeks, days, hours)	From (day/month/year)	To (day/month/year)
• Weeks:		
• Days:		
• Hours:		

5.8 Is the work you do or your weekly income different because of the accident?

No ☐

Yes ☐ ▶ Give details below

5.8.1

5.9 Have you lost income from self-employment in your own business because of the accident?

No ☐ ▶ Go to 5.13

Yes ☐ ▶ Give details below

5.9.1 Self-employment details

Name of business	Nature of business	Address (workplace)
Telephone number	Accountant's name	Accountant's address

5.10 Please give details of how much you believe you have lost and how you calculated the amount. You must be able to give the insurer copies of your taxation returns.

5.11 Is the business still operating?

No ☐

Yes ☐

5.12 Have you hired anyone to replace you?

No ☐

Yes ☐ ▶ Give details below

5.12.1 Self-employment—replacement

Name	Address	Duties performed	Cost

5.13 Have you lost wages or salary as an employee because of the accident?

No ☐ ▶ Go to 5.14

Yes ☐

5.13.1 Employment details

Name of employer	Address (workplace)	Contact person's name	Contact person's telephone number

5.13.2

Usual weekly working hours			
Ordinary		Overtime	
Standard weekly earnings			
Gross pay	Tax	Net pay	

5.13.3 Description of duties

5.14 Did you have a second job before the accident?

No ☐ ▶ Go to 5.15

Yes ☐ ▶ Give details below

5.14.1 Employment details – second job

Name of employer	Address (workplace)	Contact person's name	Contact person's telephone number

5.14.2

Usual weekly working hours			
Ordinary		Overtime	
Standard weekly earnings			
Gross pay	Tax	Net pay	

5.14.3 Description of duties

5.15 Before the accident, had you made any firm arrangements to start a new job, or stop work, or change duties, working hours, or earnings?

No ☐

Yes ☐ ▶ Give details below

5.15.1

5.16 Have you received, or will you receive, any money because of personal injuries, illnesses and disabilities either before or after the motor vehicle accident? (e.g., sick leave or holiday pay, social security benefits, worker's compensation, borrowed money, or insurance payment)

No ☐

Yes ☐ ▶ Give details below

5.16.1 If you received a social security benefit, please give your social security number. If you received worker's compensation, please give the insurer your name and claim number. If you have borrowed money, please give the lender's name and address. If you received a payment from an insurer, please give the name and address of the insurer and the claim details.

6. Payment to You/Offer of Settlement

6.1 Are you in a position to accept payment for your claim? If yes, please provide the details of the nature and extent of your loss, and the amount you would be willing to accept in full satisfaction of your claim.

No ☐ ▶ Give details below

Yes ☐ ▶ Give details below

6.1.1

If yes—

- Nature and extent of loss: _____
- Amount willing to accept: _____

If no—

Reason(s):

Authorisation and Declaration

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   (Note: An insurer includes a reinsurer and/or overseas reinsurer)

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I, the claimant (or their agent) signed hereunder, declare I understand this declaration and authorisation.

Signature of Claimant or their Agent		Date of Signing
		/ /

This form must be signed by the claimant unless he/she is either under the age of 18 years or is unable to complete it. If the claimant cannot sign because they are a minor or due to injuries sustained etc, this Form must be completed and signed by an agent for the claimant (such as a parent, guardian, relative, friend or other person who has been selected to act on behalf of the claimant).

If the claimant is unable to sign as noted in the paragraph above, please provide details of the person who signed (agent of the claimant).

Agent's Surname		Agent's Given Name(s)

Home Phone Number		Work Phone Number		Relationship to the Claimant
( )		( )		

Reason(s) why the Claimant could not sign

Documents which MUST accompany this Additional Information Form

This Additional Information Form must be accompanied by:

- A copy of any other document, etc. on which the claimant currently expects to rely for the claim that is in the claimant's possession.

Additional Information

Use this space to provide additional information to questions in the form.