Motor Accident Notification Form (MANF)

As prescribed under section 84(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

- This Motor Accident Notification Form (MANF) is the first 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)

- If you are a Claimant, you should fill out this form *first* if you are seeking early payment of medical expenses.

- In filling out this form, you must provide all documents that will assist the Insurer in processing your claim; this includes copies of receipts evidencing medical expenses.

- In providing information about pre-existing injuries exacerbated by the motor vehicle accident, you should also provide information about prior injuries, illnesses or disabilities which were not exacerbated by the motor vehicle accident. If you do not provide this information, it can affect your entitlement to claim damages and economic loss.

- In order to facilitate the processing of your claim, you should keep the Insurer informed of any changes to contact details, changes to employment details, any further medical practitioners consulted, in addition to providing additional copies of medical accounts/receipts and tax returns. These enable accurate assessment of your economic loss.

This form is Approved Form AF2008-125, 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

Motor Accident Notification Form

As prescribed under section 84(2)(a) of the *Road Transport (Third-Party Insurance) Act 2008*
For Compulsory Third-Party (CTP) Insurance Claims in the Australian Capital Territory (ACT).
This Motor Accident Notification Form is 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

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. Do you have a solicitor acting for your claim?

2.1

No ☐

Yes ☐ ▶ Give details below

2.2 Name of Firm

2.3 Name of Solicitor

2.4 Date you instructed a solicitor / /

2.5 Date you first identified the relevant insurer / /

3. Accident/Incident Details

3.1 Date of Accident / /

3.2 Time of Accident ☐ am ☐ pm

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

Postcode

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

Yes ☐ ▶ Give details below

No ☐ If no, go to asterisk (*) on next page

3.5 Registration Number including state registered in

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

3.7 Colour and body type (if known)

3.8 Name and address of owner (if known)

Postcode

3.9 Home Phone Number ( )

3.10 Work Phone Number ( )

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

Postcode

3.12 Home Phone Number ( )

3.13 Work Phone Number ( )

3.13.1 To the best of your knowledge, had the driver consumed any alcohol or drugs in the last 12 hours before the accident?

No ☐

Yes ☐

*****There is an obligation on you as the claimant to provide evidence of steps taken to find out the registration number or the owner of the vehicle you consider at fault. Please list any action taken by you to find the registration number or the name of the person who drove the vehicle you consider at fault. (Please attach any proof such as newspaper advertisement or discussions with any witnesses, etc.)

3.14 Steps taken to find details of the most at fault vehicle:

Details of the other vehicle(s) involved in the accident:-

3.15 Registration Number including state registered in

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

3.17 Colour and body type

3.18 Name and address of owner (if known)

Postcode

3.19 Home Phone Number ( )

3.20 Work Phone Number ( )

3.21 Name and address of driver (if known)

Postcode

3.22 Home Phone Number ( )

3.23 Work Phone Number ( )

3.23.1 To the best of your knowledge, had the driver consumed any alcohol or drugs in the last 12 hours before the accident?

No ☐

Yes ☐

If more than two vehicles involved please provide details of other vehicles on a separate piece of paper.

3.24 Please provide a description of the accident.

3.25 What was your role in the motor vehicle accident?

Driver ☐

Passenger ☐

Pedestrian ☐

Cyclist ☐

Motor cyclist ☐

Other – please provide details

3.26 Please provide the registration number of the vehicle you were in, if applicable:-

3.27 If you were a driver/passenger, were you wearing a seatbelt?

No ☐

Yes ☐

3.27.1 If not, please provide details

3.28 If you were a cyclist, motorbike rider or pillion passenger, were you wearing a helmet?

No ☐

Yes ☐

3.28.1 If not, please provide details

3.29 Had you consumed any alcohol or drugs in the last 12 hours before the accident?

No ☐

Yes ☐

3.30 If yes, please provide details including the amount of alcohol consumed and when it was consumed.

Police/Services Report

3.31 Do you know if Police, Ambulance, Fire Brigade or any other emergency service attended the accident?

No ☐

Yes ☐ ► Give details below

3.32 Name of Service(s) and/or officers (if known)

Station

3.32.1 Date accident reported to police

/ /

3.32.1.1 Traffic Incident Number (If known)

3.33 Do you know if there were any witnesses or if any witness statements were taken (for example by Police)?

No ☐

Yes ☐ ► Give details below

Witness 1 (If known)

3.34 Surname

3.35 Given Names

3.36 Home Address

Postcode

3.37 Home Phone Number ( )

3.38 Work Phone Number ( )

Witness 2 (If known)

3.39 Surname

3.40 Given Names

3.41 Home Address

Postcode

3.42 Home Phone Number

3.43 Work Phone Number

Please attach a list with these details if there are more than two witnesses.

3.44 Did anyone or anything other than the other driver cause or contribute to the accident? For example: the condition of the road.

No ☐

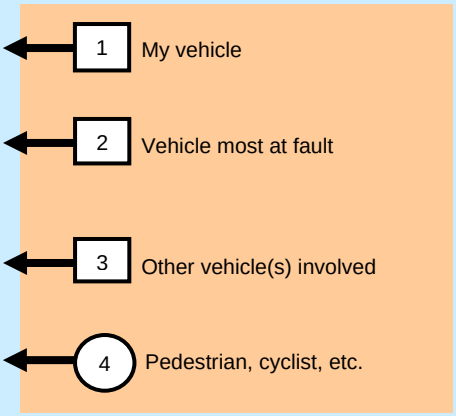
Yes ☐ ► Give details below

3.45 Diagram of Accident

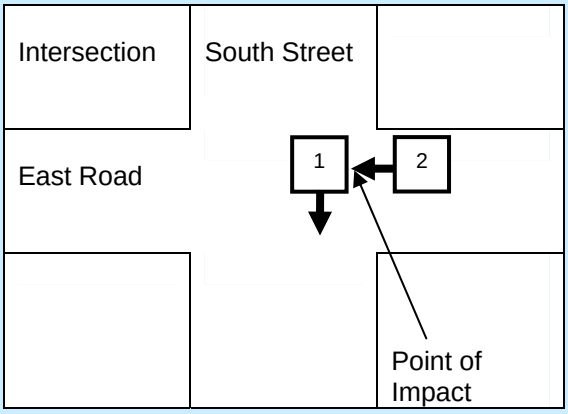
Draw a diagram of the accident. Include all intersections, streets, roads and their names. Show the point of impact and position of vehicles.

Use this box 

Symbols



Example diagram



3.46 Are you receiving, or entitled to, workers' compensation as a result of this accident?

No ☐

Yes ☐ ▶ Give details below

3.47 Name of Insurance Company

3.48 Policy Number (if known)

3.49 Have you lodged a claim?

No ☐

Yes ☐ ▶ Give details below

3.50 Date Claim Lodged

/ /

3.51 Claim Number

4. Employment Details

4.1 Please advise your employment at the time of the accident.

- ☐ Full time employed
- ☐ Part time employed
- ☐ Self employed
- ☐ Casual
- ☐ Retired
- ☐ Student/Child
- ☐ Home duties
- ☐ Not working
- ☐ Pension (please describe):
- ☐ Other (please describe)

Please provide your employment details/job type.

4.2 Occupation/Job Type

4.3 Name of Employer

4.4 Contact Person's Name for Employer

4.5 Employer's Contact Phone Number

( )

4.6 Workplace Address

Postcode

4.7 Please describe your work duties

Usual Weekly Working Hours

4.8 Ordinary

4.9 Overtime

Average Weekly Earnings prior to the accident
(include overtime, regular bonuses and commissions)

4.10 Gross (before tax)

$

4.11 Net (after tax)

$

4.12 Have you lost any income as a result of this accident?

No ☐

Yes ☐

4.13 Have you returned to work?

Yes ☐ 4.14 Date returned to work / /

No ☐ 4.15 Date you expect to return to work / /

4.16 Is the work you do or your weekly earnings different because of the accident?

No ☐

Yes ☐ ▶ Give details below

4.17 If self employed:-

Have you lost income because of the accident?

No ☐

Yes ☐ ► Give details below

4.18

4.19 Name and nature of business

4.20 Accountant's name

4.21 Accountant's contact details

Postcode

Phone Number ( )

5. I confirm that the information provided in this form is true and correct to the best of my knowledge.

Signed:

Print Name:

Date: _____ / _____ / _____

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 Notice 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 Names

Home Phone Number

Work Phone Number

Relationship to Claimant

Reason(s) why the Claimant could not sign

Authorisation and Declaration

Protection of Privacy

- The information collected by this Motor Accident Notification 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 Motor Accident Notification 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.

   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 Motor Accident Notification Form

The Motor Accident Notification Form must be accompanied by the following documents:

- The Motor Accident Medical Report which is attached to this form;
- 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.