

**South Australia Compulsory Third Party (CTP)**

# Injury Claim Form

This form is to be completed by any person who is injured in a motor vehicle accident (please refer to Page 3 for more information).

**A driver, motorcyclist or registered owner is required to report when a person is injured in a motor vehicle accident (refer section 124 of the Motor Vehicles Act).**

Completing the Accident Report Form will ensure you comply with this requirement. The form can be found at [www.allianz.com.au/sactp](http://www.allianz.com.au/sactp) or available at Allianz (refer address below).

If your motor vehicle is damaged, you may also need to report the accident to your motor vehicle insurer. You should check your reporting requirements with them.

**This form may be lodged by:**

**Mailing to:**

Allianz Australia SA – CTP  
GPO Box 2198  
Adelaide SA 5001

**or faxing to:**

Allianz Australia SA – CTP  
General Fax 1300 137 431  
(cost of a local call)

**or lodging personally to:**

Allianz Australia SA – CTP  
Ground Floor, 89 Pirie Street  
Adelaide SA 5000

If you have any queries, please call Allianz Australia SA – CTP Personal Injury Helpline on 1300 137 331 (cost of a local call). Alternatively, further information may be found on the Allianz website: [www.allianz.com.au/sactp](http://www.allianz.com.au/sactp)

**PLEASE COMPLETE THIS FORM IN EITHER BLUE OR BLACK PEN.**



## Other languages

If you need an interpreter please call the Translating and Interpreting Service (TIS National) on 131 450 and ask to be connected to Allianz on 1300 137 331 between 8:30 am and 5:00 pm, Monday to Friday.

### ITALIANO

Se avete bisogno di un'interprete chiamate il Translating and Interpreting Service (TIS National) al 131 450 e chiedete di essere collegati con Allianz al 1300 137 331 tra le 8:30 e 5:00, dal lunedì al venerdì.

### Ελληνικά

Εάν χρειάζεστε διερμηνέα παρακαλείστε να τηλεφωνήσετε στην Υπηρεσία Μεταφραστών και Διερμηνέων (TIS National) στον αριθ. 131 450 και να ζητήσετε να σας συνδέσουν με την εταιρεία Allianz στο 1300 137 331 μεταξύ 8:30 π.μ. και 5:00 μ.μ. Δευτέρα με Παρασκευή.

### Tiếng Việt

Nếu quý vị cần thông dịch viên, xin liên lạc với Dịch Vụ Thông Phiên Dịch (TIS National) qua số điện thoại 131 450, và xin được nối đường dây với Allianz qua số 1300 137 331, từ 8 giờ 30 sáng đến 5 giờ chiều, thứ Hai đến thứ Sáu.

### 한국어

통역사가 필요하시면 통역 및 번역 서비스 (TIS 전국)에 월요일 부터 금요일 오전 8시30분 에서 오후 5시 사이에 131 450 으로 전화 하십시오. 그리고 알리안츠 (Allianz) 전화 1300 137 331에 연결 해 달라고 요청 하십시오.

### 普通话

如果您需要口译服务，请拨打国家翻译与口译服务处（简称 TIS National）电话 131 450，并要求与安联保险公司（Allianz）联系（时间：周一至周五上午 8：30 至下午 5：00，电话：1300 137 331）。

# What you need to know about this form

If you have been injured in a road crash you may be entitled to compensation.

If your accident happened on or after 1 July 2013 or you have not previously made a claim for your injuries, you are required to complete this claim form.

The form will allow you to provide details about the accident and your injuries to Allianz (MAC's Claims Manager) which will manage your claim. The information will enable Allianz to make informed decisions about your claim, and help you to promptly access medical treatment to optimise your recovery.

The more information you are able to provide in this claim form, the quicker Allianz will be able to process your claim and make informed decisions. If there is not enough room to answer a question, additional space is provided on Page 11. Please make it clear on Page 11 which question you are responding to.

If you are under the age of 18, this form should be signed by a parent or guardian on your behalf.

You will be required to provide the relevant police report number (Question 22 on Page 05) and a medical certificate or opinion from your doctor as to the nature and probable cause of your injuries.

The form also contains an authority for Allianz to collect additional information to assist them in processing your claim. You are required to complete both the claim form and this authority. Allianz is required to provide you with a copy of any information obtained using the authority within 21 days of Allianz receiving that information.

There is provision on Page 10 for you to nominate someone to communicate with Allianz on your behalf. Please complete this Nominee Authority if required.

## How long do I have to submit the claim form:

You are required to submit this claim form to Allianz:

- as soon as reasonably practicable where:
  - (1) the identity of the motor vehicle at fault is not known, or
  - (2) the motor vehicle at fault was not insured, or;
- within 6 months of the motor vehicle accident in any other case.

## What happens if the claim form is not completed?

Allianz may decline to consider or deal with your claim if the claim form and authority are not properly completed or submitted outside the time frames listed above.

## Where do I get more help to complete this form?

Please contact Allianz if you require any further information or assistance in completing this claim form.

Further information about the claims process can be found at:

- Allianz website ([www.allianz.com.au/sactp](http://www.allianz.com.au/sactp))
- MAC website ([www.mac.sa.gov.au/claim](http://www.mac.sa.gov.au/claim))

## Extra information relating to children under 16:

If the motor vehicle accident occurred in South Australia and you were under the age of 16 at the time and the accident occurred on or after 1 July 2013, this claim form should be lodged with Allianz regardless of whether or not a South Australian registered vehicle was involved.

# About me

Office Use: Claim Number

## Personal details

1 Mr  Ms  Mrs  Miss  Other

Surname

Given names

Have you been known by another name? Yes  No

If yes, surname

Given names

2 Male  Female

3 Date of birth / /

Country of birth

4 Language spoken at home

5 Do you require an interpreter? Yes  No

6 Home address

Postcode

Postal address (if different to the above)

Postcode

7 Home phone no ( )

Work phone no ( )

Mobile no

Email

8 Medicare no

9 Driver's Licence number

State Expiry date / /

Please attach a copy of your Driver's Licence

10 Occupation

Name of employer(s)

Work address(es)

11 Are you receiving or entitled to any type of benefit or other compensation? Yes  No

If yes, please indicate below

Centrelink (type)

Workers Compensation (name of Workers Compensation insurer, exempt employer or claims agent)

Invalid / Disability Income Protection (name of insurer)

Other (details)

12 Have you had any injuries or illness – before or since the accident – to the same part(s) of your body? Yes  No

If yes, please include approximate date, injury or illness, treating doctor etc, as appropriate.

13 Have you been involved in ANY accidents in which you were injured prior to or since this accident? (e.g. motor vehicle accident, sports, work, home) Yes  No

If yes, please include approximate date of injury, treating doctor, type of claim, insurer etc as appropriate. You should also advise Allianz if you have another accident while your claim is progressing.

14 Have you made any kind of personal injury or illness claim before? Yes  No

If yes, please include approximate date, injury or illness, treating doctor, type of claim, insurer etc as appropriate.

15 Name of person completing the form (if not injured person)

Relationship to injured person

Reason why injured party is not completing this form?

# About my accident

## Accident details

If you were the driver of a vehicle involved in the accident AND have completed an Accident Report Form, please go to Question 32.

16 Were you a  Driver/Rider  Cyclist   
 Passenger/Pillion  Pedestrian  Other

17 Date of accident / / Time of accident am/pm

Weather

Road conditions

Place of accident

Suburb Postcode

18 How many vehicles were involved in the accident?

*If you were a cyclist or pedestrian, please go to second vehicle, Question 20*

## First vehicle

19 Details of vehicle you were travelling in.  
Mr  Ms  Mrs  Miss  Other

Driver Surname

Given names

Driver phone no ( )

Driver address

Postcode

Registration no

State of registration

Year (e.g. 1990)

Make and model (e.g. Mazda 6)

Body type (e.g. Sedan)

Colour

## Second vehicle

20 Details of other vehicles involved in the accident (if known).  
Mr  Ms  Mrs  Miss  Other

Driver Surname

Given names

Driver phone no ( )

Driver address

Postcode

Registration no

State of registration

Year (e.g. 1990)

Make and model (e.g. Mazda 6)

Body type (e.g. Sedan)

Colour

*Please continue on Page 11 if there are more than 2 vehicles involved.*

## Witness(es) details

21 Were there any witness(es) Yes  No  Unknown

*If yes, please give details below*

*If no, please go to Question 22*

Witness 1

Mr  Ms  Mrs  Miss  Other

Witness Surname

Given names

Witness phone no ( )

Witness mobile

Witness address

Postcode

Witness 2

Mr  Ms  Mrs  Miss  Other

Witness Surname

Given names

Witness phone no ( )

Witness mobile

Witness address

Postcode

## Police report

22 Did the Police come to the scene of the accident? Yes  No  Unknown

Did you report the accident to the Police? Yes  No

Police Report no

Police station

23 Is Police action going to be taken? Yes  No  Unknown

*If yes, name of person charged*

Offence charged

## Circumstances of accident

24 Were you wearing a properly adjusted and fastened seat belt? Yes  No  Not applicable

*If not applicable, please give details*

25 If you were on a bicycle or motorbike, were you wearing a fastened safety helmet? Yes  No

If yes, was it securely fitted? Yes  No

26 Had you had any drugs, including medication or alcohol, in the 12 hours before the accident? Yes  No

*If yes, please give details of how much, what and when*

27 (i) Did you have a breathalyser test conducted? Yes  No  Unknown

If yes, provide result(s) and attach docket if provided

(ii) Was a drug test conducted? Yes  No  Unknown

If yes, what was the result?

(iii) Did you go to hospital? Yes  No  Unknown

(iv) Did you have a blood sample taken? Yes  No  Unknown

If yes, please provide result and attach certificate (both pages)

If not available please provide at first available opportunity

28 If you were a passenger in a vehicle, or a passenger on a motorbike, had the driver or rider had any alcohol and/or drugs, including medication in the 12 hours before the accident? Yes  No  Unknown

If yes, please give details – how much, what and when

29 Please mark with a ✓ your position in or on the vehicle.



30 Description of the accident. (Describe how the accident happened and include a reference to road conditions, speed, traffic lights, road signs, peak hour etc and details of vehicle damage).

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Please continue on Page 11 if you need to include more information.

31 Diagram of accident. (Please draw a diagram of the accident. Include intersections, streets, roads and their names. Show the point of impact and position of all vehicles).

**Symbols to use**

- traffic sign
- traffic lights
- witness
- pedestrian
- your vehicle (black)
- other vehicles 1, 2, 3

**Example diagram for vehicle**

**Example diagram for pedestrian/cyclist**

**Check list**

Please show  street names  lanes/lines markings  traffic signals/signs

Vehicle 1 registration .....

Vehicle 2 registration .....

Vehicle 3 registration .....


# About my injuries

## Injuries

32 What are your injuries from the accident?

*(List all injuries. Please continue on Page 11 if you need to include more information).*

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## Treatment

33 Were you taken by ambulance from the accident scene? Yes  No

34 Did you go to hospital? Yes  No

*If yes, please give details*

Name of Hospital

Was this a casualty attendance only or were you admitted?

Casualty  Admitted

If admitted, admission date / / discharge date / /

35 Did you seek treatment from a private doctor? Yes  No

*If yes, please give details*

Doctor's name

Date of visit / /

36 Who has treated you for your injuries since the accident?

*(List all doctors, surgeons, physiotherapists, specialists, etc. Please continue on Page 11 if you need to include more information).*

(i) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

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(ii) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

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(iii) Name of person treating you

Phone no ( )

Date first seen / /

Address (practice or surgery)

Postcode

What treatment have you had?

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37 Are you still receiving treatment? Yes  No

*If yes, please give details (e.g. physiotherapy, chiropractic, etc, including name and address).*

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How long do you expect treatment to continue?

Days  Weeks  Months  Longer

38 How do the injuries affect you NOW?

*(Please continue on Page 11 if you need to include more information.)*

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# About my claim

(You will need to supply a medical certificate or opinion from your doctor to support your claim)

## Medical expenses

40 Have you incurred any medical expenses? Yes  No

*Please attach all accounts you have to this claim form for consideration by Allianz*

## Income

41 Have your injuries prevented you from working in your normal duties? Yes  No

*If no, go to Question 47  
If yes, please explain how*

42 Date you stopped work or were prevented from performing your normal duties due to the accident / /

43 Have you returned to work? Yes  No

44 Have you returned to normal pre-accident duties and hours? Yes  No   
*If no, please provide details*

45 Are you employed? Yes  No

*If no, please go to Question 46*

Occupation

Name of employer

Contact person's name

Contact phone no ( )

Work address

Postcode

Usual weekly working hours Overtime

Usual weekly earnings (including overtime, regular bonuses & commission)

Gross pay \$ Net pay \$

*Please describe your duties*

Details of lost income (please attach payslips or group certificate)

Name of other employer (if applicable)

Contact person's name

Contact phone no ( )

Work address

Postcode

Usual weekly working hours Overtime

Usual weekly earnings (including overtime, regular bonuses & commission)

Gross pay \$ Net pay \$

*Please describe your duties*

Details of lost income (please attach payslips or group certificate)

46 Are you self-employed? Yes  No

*If no, please go to Question 47*

Occupation

Work address

Postcode

Usual weekly working hours

Usual weekly earnings \$

*Please describe your duties*

Details of lost income (please attach your most recent notice of assessment or financial statement)

## Other losses

47 Have you suffered any other losses or incurred other expenses relating to this claim (excluding damage to your vehicle or personal items) that you wish to have considered (eg. assistance at home or travel for treatment)?

Yes  No  Unknown

*If yes, please provide details*



# Statement giving authority to obtain information

## Schedule 1 – Motor Vehicles (Third Party Insurance) Regulations 2013

By completing this authority to obtain information (the authority) you are giving the Motor Accident Commission and its agent/s, including Allianz, permission to obtain documentary information relevant to processing and assessing your claim.

I (please print)

date of birth / /

authorise Motor Accident Commission and its agent/s, including Allianz, to obtain documentary information relevant to my claim for damages or other compensation (specify):

sustained on or about (date) / /

from the following people/organisations

- (a) insurers that carry on the business of providing -
  - (i) compulsory third party insurance; or
  - (ii) private health insurance; or
  - (iii) motor vehicle insurance; or
  - (iv) workers compensation insurance;
- (b) health practitioners;
- (c) hospitals, including private hospitals;
- (d) ambulance or other emergency services;
- (e) professional providers of rehabilitation services or persons professionally qualified to assess cognitive, functional or vocational capacity;
- (f) educational institutions;
- (g) my employer or my previous employer;
- (h) departments, agencies or instrumentalities of the Commonwealth, the State or another State, administering laws about health, police, transport, taxation or social welfare;
- (i) the Lifetime Support Authority of South Australia;
- (j) the WorkCover Corporation.

I approve a copy of the authority, including an electronic version, being treated as the original.

This authority is valid for the duration of my claim (unless revoked after the expiration of 6 months from the date of execution of the authority).

Signed

Date / /

*Details and signature of witnessing party (any person over 18 years of age)*

Full name of witness

Signature of witness

Date / /

### Note:

1. If you wish to make a claim for damages or compensation you must sign this authority. This is required by law.
2. This authority will remain in force until your claim is resolved or you revoke it. However, you can not revoke this authority for at least 6 months after you sign it.
3. Prior to using this authority to obtain information, the Motor Accident Commission, nominal defendant or agent must ensure the authority is valid and the information is relevant.
4. The claimant has the right to seek independent legal or other advice before signing the authority. You will be responsible for paying any fee for the advice.
5. The Motor Accident Commission/nominal defendant or claims agent must provide you with a copy of any documents that they obtain under this authority within 21 days of receipt of those documents.

# Declaration

Please read the Declaration carefully before signing.

It will assist us in dealing with your claim if the declaration is properly completed and witnessed.

The injured person should sign the declaration unless he/she is under 18 years of age or is unable to make the declaration. In this case a parent or guardian of the injured person should sign the declaration.

All information you have given in the claim form must be true and correct in every respect.

**Under Section 124(6a) of the *Motor Vehicles Act 1959*, you can be fined up to \$50,000 or be imprisoned for up to one year for knowingly providing false or misleading information.**

I (full name) .....

declare that, to the best of my knowledge, the information given in this Claim Form is true and correct in every respect.

Signature of claimant .....

.....  
*(Parent or guardian must sign if claimant is under 18 years of age)*

Date / / .....

*Details and signature of witnessing party (any person over 18 years of age)*

Full name of witness .....

Signature of witness .....

.....  
Date / / .....

# Nominee Authority

Authority to communicate directly with nominee. Please complete this if you need Allianz to communicate with your nominee.

I authorise Allianz (or its agents) to communicate directly with my nominee (as detailed below).

This authority will extend to, but is not limited to, discussing relevant private matters and supplying and receiving oral and written information and will remain in force until withdrawn by me in writing.

Signature of claimant .....

.....  
Date / / .....

*(Parent or guardian must sign if claimant is under 18 years of age)*

Witness details .....

Name .....

Signature .....

.....  
Date / / .....

## To be completed by nominee

I ..... (name)

of .....

..... (address)

accept the role of communicating on behalf of the above claimant with Allianz and undertake to keep confidential (other than with the claimant) any information gathered while occupying this role.

Signature of nominee .....

.....  
Date / / .....

Witness details .....

Name .....

Signature .....

.....  
Date / / .....

# Additional space

Space used for further information

A series of horizontal dotted lines for writing, occupying the left half of the page.

A series of horizontal dotted lines for writing, occupying the right half of the page.

Please  
attach extra  
pages if  
required



**We appreciate that your time is valuable; however the more information you can supply at this stage will assist us in processing your documentation.**

Please ensure you have completed the following:

- Reported the accident to the police.  
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- Nominated the motor vehicle (registration) and person you consider caused the accident.  
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- Signed the declaration on Page 10 in the presence of a witness over the age of 18.  
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- Attached proof of age if you were under 18 years of age at the date of accident.  
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- Attached medical certificate or opinion from your doctor.  
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- Attached to the claim form any original accounts, receipts or invoices you may already have.  
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- Attached proof of income (if relevant).  
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- Made a copy of the claim form, medical certificates, accounts, invoices, etc for your own record.  
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- Attached a copy of your driver's licence (or other proof of identity), breath analysis and/or drug analysis docket, or Blood Alcohol certificate (2 pages) where available.  
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Please ensure that all other sections of the form/s are completed to the best of your ability.

**If you have any questions about the completion of the forms please contact us on 1300 137 331 and we will be happy to assist with your enquiry.**