MOTOR ACCIDENT NOTIFICATION FORM

MOTOR ACCIDENT MEDICAL REPORT

Information for applicant

This joint Motor Accident Notification Form and Motor Accident Medical Report (MANF / MAMR) may be used to seek early payment for medical expenses associated with a motor accident. You have 30 working days from the accident to submit the form for early payment. Keep a copy of the completed form as you will need to provide a copy if you complete a Notice of Claim Form (to commence a claim under section 84 of the *Road Transport (Third-Party Insurance) Act 2008* (the Act)).

If you are proceeding with a notice of claim (ie. did not seek early payment of your medical expenses), you need to complete this form to provide the motor accident details and the medical report.

Who to submit the form to?

If you have not identified the vehicle that caused the accident (the 'at-fault' vehicle), the joint MANF / MAMR form is to be provided to your insurer (referred to as the injured person's insurer). If the police accident report has identified the vehicle that caused the accident and identified the insurer, the MANF / MAMR form may be submitted to the at-fault vehicle's insurer (referred to as the at-fault insurer).

The insurer you submit the MANF / MAMR to may identify that another insurer should manage the claim (eg. the at-fault vehicle's insurer). They are obliged to inform you that another insurer will be handling your claim and arrange to transfer your form to that insurer, if they elect not to manage the application. The at-fault insurer will contact you regarding your early payment request.

If the at-fault vehicle is unregistered, unidentified or subject to an unregistered vehicle permit, you should submit the form to the Nominal Defendant. If you do not have an insurer because you were a passenger, pedestrian or cyclist, you should provide the MANF / MAMR to the insurer of the vehicle you believed or are informed by the police caused the accident.

This information is to assist you in accessing early treatment and monetary assistance for your injuries. If you commence with or proceed to a notice of claim, the at-fault insurer is the insurer for your notice of claim.

For help with this form in a language other than English please call the
Telephone Interpreter Service (TIS) on 131 450.

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MOTOR ACCIDENT MEDICAL REPORT

This form was approved by the CTP regulator for the purposes of section 276 of the R*oad Transport (Third-Party Insurance) Act 2008* (prescribed by section 69 (Motor Accident Notification Form) and section 70 (Motor Accident Medical Report)).

Protection of Privacy

- The information collected by this Motor Accident Notification Form/Motor Accident Medical Report (MANF / MAMR), and throughout the course of your claim, is collected in accordance with the *Road Transport (Third-Party Insurance) Act 2008* (the Act) and Road Transport (Third-Party Insurance) Regulation 2008 (the 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 MANF / MAMR and throughout the course of your claim may be disclosed in accordance with the Act and the Regulation to such bodies as: the CTP regulator, the Nominal Defendant, and other insurers or parties involved in the assessment of your claim.
- 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 ACT Government, as provided by the road transport legislation and the *Information Privacy Act 2014* (ACT).
- Any personal information you provide to the CTP Insurer will be collected, held, used and disclosed in accordance with their Privacy Policy. You will be able to view their privacy policy on their website or you can request that the Insurer send you a copy.

Claim Number:
Insurer issued

Section 1: Your details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Dr ◯ Other

Full Name

Previous Name

Street Address

City State Post code

E-Mail Address Phone Number

Date of Birth Medicare No.

Drivers' licence No. Do you need an interpreter? Language?

Occupation and Employer

Section 2: Accident details

Your role in the accident

- ◯ Driver
- ◯ Pedestrian
- ◯ Motorcyclist
- ◯ Passenger
- ◯ Cyclist
- ◯ Pillion Passenger
- ◯ Other

How many vehicles were involved

Date of accident

Time:

- ◯ AM
- ◯ PM

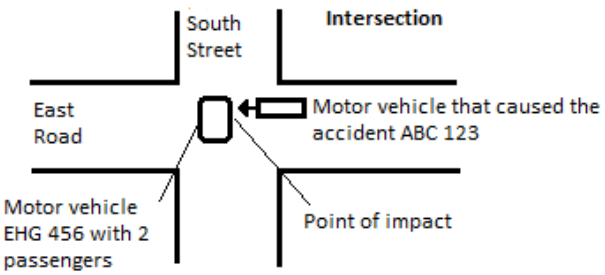
Place of accident (Street, Suburb, Town and State) - including nearest cross road, property number or landmark

Road and weather conditions

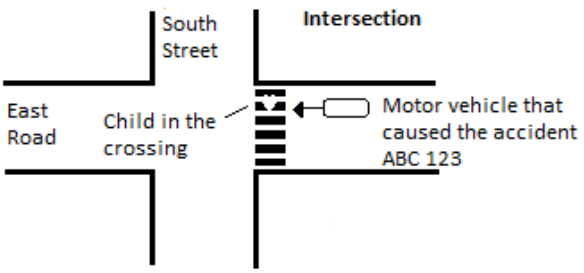
Describe how the accident occurred and/or provide a diagram below

Diagram

Example diagram of a motor vehicle



Example diagram for pedestrian/cyclist



Who or what caused the accident and how/why?

If you are unable to identify the vehicle at fault, please list what steps you have taken to identify the vehicle

Vehicle that is believed to have caused the accident

Registration and State | Make (eg. Toyota) | Body Type (eg. sedan) | Model (eg. Camry)

People in the vehicle (no.) | Driver Name

Email Address | Contact number

Address

Had the Driver/Rider had any Alcohol, Drugs or Prescription medication in the 12 hours prior to the accident?

Yes ☐ Which: ☐ Alcohol ☐ Drugs ☐ Prescription ☐ Don't know

Vehicle owner name if not driver | Contact number

Address

Vehicle you were travelling in or on
(if driver or passenger in vehicle caused the accident, write 'as above')

See question below for pedestrian, cyclist

Registration and State | Make (eg. Toyota) | Body Type (eg. sedan) | Model (eg. Camry)

People in the vehicle (no.) | Driver Name

Email address | Contact number

Address

Had the Driver/Rider had any Alcohol, Drugs or Prescription medication in the 12 hours prior to the accident? 4

Yes ☐ Which: ☐ Alcohol ☐ Drugs ☐ Prescription ☐ Don't know

Vehicle owner name if not driver

Contact number

Address

Pedestrian/Cyclist/Other

Were you wearing a helmet? ◯ Yes ◯ No ◯ Not applicable

Did you have any Alcohol, Drugs or Prescription medication in the 12 hours prior to the accident?

Yes ☐ Which: ☐ Alcohol ☐ Drugs ☐ Prescription

For any other vehicles involved in the accident or a multiple vehicle accident, please provide vehicle registration details and driver details on a separate sheet of paper.

Witnesses, if available

Full name

Address

Contact Number

Alternate contact number

Please provide the full name, address, contact number and alternate contact number if there is more than one witness to the accident. This is to be attached as a separate sheet of paper.

Section 3: Police Attendance/Report

Did police attend? ◯ Yes ◯ No

Police accident reference no.

If police did not attend, date reported?

Reported to Police Officer name and rank, station

You must report this accident to Police. If you have a copy of the Police Accident Report please attach it to this form, otherwise you have 14 days to provide it to the insurer after you receive it.

Section 4: Medical Information (to be completed by your doctor)

Patient's name

Medicare No.

Date of Birth

Date patient first attended in relation to accident

How long has the patient attended the practice?

Medical diagnosis or description of injury

Clinical findings (symptoms, investigation results)

Are the injuries consistent with the circumstances of the motor accident described to you? ◯ Yes ◯ No

Has the patient been treated for a similar condition or had an injury to the same area in the past? ◯ Yes ◯ No

If yes, please give details

Has a pre-existing injury become aggravated by the accident? ◯ Yes ◯ No

If yes, please give details

Was the patient attended by an ambulance?

◯ Yes
◯ No

Did the patient attend hospital?

◯ Yes
◯ No

Was the patient admitted to hospital?

◯ Yes
◯ No

Name of hospital

Admitted for longer than 24 hours? ◯ Yes ◯ No

Is treatment likely to be required:

☐ Short term (6 weeks)
☐ Medium term (6-12 weeks)
☐ Long term (>12 weeks)
☐ No treatment necessary

Treatment type ☐ GP Management ☐ Allied Health Therapy ☐ Specialist ☐ Other

Treatment plan, referrals (including provider details), recommendations and advice to patient (including details of treatment/rehabilitation already undertaken

Details

Patient's fitness for work

Unfit for work from: until Date of next review:

Fit to resume normal duties with restrictions from: Restrictions:

Fit to resume normal duties on:

Doctor's information (print if not filling in electronically)

Doctor's name Work phone no.

Speciality/ professional qualification

Provider no. If stamp available, place here:

Name of practice/hospital

Practice/ hospital address

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 Date

Declaration and authority to obtain information

I declare that I was not wholly or mainly at fault in the motor accident. Declaration required under section 72(1)(c)(i) of the Act.

For the purpose of assessing my claim, I hereby authorise the insurer against whom this notice is made, to contact and obtain information and documents relevant to the claim for the payment of early medical expenses under Chapter 3 of the Road Transport (Third-Party Insurance) Act 2008, for injury sustained in the accident which occurred on the date mentioned in Section 2 of this form as follows:-

1. Clinical notes in the possession of a health service provider who treated or assessed me in relation to the personal injury ("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 injury.
4. Records in the possession of an Ambulance or other emergency service that treated or assisted me in relation to the 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. 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.

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

I, the claimant (or their agent) signed hereunder, declare the information provided is true and correct and that I understand this declaration and authorisation. I acknowledge that this authority is provided for by legislation and the consent provided in this authority cannot be withdrawn.

Signature - claimant or agent		Date	
Print Claimant's Full Name		Date of Birth	

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 is unable to sign, 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 the claimant). Please provide details of the person who signs as agent of the claimant below:

Agent's full name		Date of Birth	
Relationship to claimant		Contact no.	
Previous name (if applicable)			
Reason(s) claimant cannot sign			

Please keep a copy of the completed and signed form. you will need to provide a MANF/MAMR form in the event you proceed with a claim.