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Personal Accident Claim Form

1. AGENCY DETAILS

Agency Name	Phone
Postal Address	Fax
Risk/Cost Centre	

2. ACCIDENT AND TREATMENT DETAILS

1. Details of Injured Person:

Family Name Given Name(s)

Address

Date of Birth / / Occupation Gender: Male Female

2. Name and Address to whom the compensation is to be paid (if different from above):

Family Name Given Name(s)

Address

Date of Birth / / Occupation Gender: Male Female

3. Date of Incident / / Time am/pm Date Ceased Paid Work / /

Date Returned to Paid Work / /

4. What actually happened and what caused the personal injury? Include:

(i) what action was involved, e.g. fall, caught between, struck by moving object

.....

(ii) what object/machine/substance was involved, e.g. petrol fumes, wooden door frame

5. Describe:

(a) the most serious injury or disease caused by the occurrence, e.g. fracture, burn, cut, abrasion

.....

(b) the bodily location of the injury or disease, e.g. upper arm, ankle, eye

(c) the physical location where the personal injury took place, e.g. escalator

6. Was the part of the body affected or injured by this occurrence healthy before the occurrence? Yes No

If No, provide details

7. How long has the person been confined to:

Bed: From / / to / /

House: From / / to / /

Hospital: From / / to / /

8. Advise name and address of doctor(s) attending the person

.....

.....

If admitted to Hospital, advise name of Hospital

(Please attach any medical certificates or supporting documentation)

9. Has the person required medical or surgical treatment during the past twelve months? Yes No

If Yes, give particulars

.....

10. Is there any Income Protection Insurance(s) covering this claim? Yes No

If Yes, advise name of Insurance Company and Policy No.

11. Is the person a member of any government or private health insurance fund or scheme? Yes No

If Yes, advise details

.....

Please complete other side of form

IMPORTANT NOTICE - If applicable, please complete section(s) 3,4,5 and/or 6, otherwise complete section 7

3. WORK EXPERIENCE

At the time of incident:

- (a) What school was the student attending?
- (b) Was the student participating in a school organised work experience program? Yes No
- (c) What was the name and address of the Host Employer the student was employed by?
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- (d) What were the student's duties?
-
- (e) Did the student receive any wages for the work experience program undertaken? Yes No

4. SCHOOL GROUP ACTIVITY STUDENTS

At the time of incident:

- (a) What school was the student attending?
- (b) Was the activity a part of an overnight excursion? Yes No

5. MOTOR VEHICLE INCIDENT DETAILS

1. Details of Driver:

Name:

Address:

2. Details of Vehicle: Make Registration Number

3. Street and Locality where incident occurred:
.....

4. Who do you consider to have caused the incident and why?

.....

5. Has a claim been lodged against the Insurance Commission of WA, Motor Vehicle Personal Injury Division? Yes No

If Yes, provide the claim number

6. WITNESS DETAILS (to the injury)

Name	Address	Daytime Contact Number
.....
.....

7. DECLARATIONS

Injured Person's Declaration

I declare that the details submitted are true and correct.
I hereby authorise any DOCTOR, HOSPITAL, CLINIC, OR
OTHER PERSON to give RiskCover any and all information
concerning this claim.

.....
Signature of person, parent or guardian

Name of Signatory

Relationship to Claimant
(if other than Claimant)

Date / /

Agency Authorisation

I declare that I am the person authorised to lodge the claim
against RiskCover on behalf of the above-mentioned Agency.

.....
Signature of person having authority

Name

Phone

Position

Date / /