

EMERGENCY TRANSPORT CLAIM FORM

Emergency Ambulance Cover is provided via Incolink's Discretionary Fund and is governed by the Discretionary Guidelines

OFFICE USE ONLY

Claim number

Reference

COMPLETE THIS FORM IF

An ambulance has been used within Australia. Incolink guidelines will be followed when assessing this claim. Incomplete answers and vague information will delay the assessment of the claim.

FORWARD THIS CLAIM FORM TO

Total Claims Solutions
Level 1, 151 Rathdowne Street
Carlton VIC 3053

Or email:
claimsVIC@totalclaims.com.au

FOR CLAIM ENQUIRIES CALL

Total Claims Solutions
(03) 9320 8588

INSTRUCTIONS

Claim Form

The **WORKER** must complete ALL questions on pages 1 and 2 of the form once the Ambulance invoice has been received.

This claim must be supported by proof of identity.

Acceptable Documents

1. A current Australian drivers license, or
2. A current Australian passport

IMPORTANT

The **ORIGINAL** fully completed claim form must be sent with **ALL DOCUMENTS** outlined in the checklist.

CHECKLIST

- ☐ Proof of dependant(s)
- ☐ Original ambulance invoice
- ☐ Proof of identity
- ☐ Proof of bank details

The issue of this form **DOES NOT** constitute admission of liability on our behalf.

Section A

WORKER

WORKER DETAILS

1. Incolink member number 	2. Are you a union member? ☐ No ☐ Yes ☐ Name of union
3. Given name(s) 	Surname
4. Date of birth DD / MM / YYYY	
5. Street Address (no PO Box) 	Suburb
	Postcode
6. Home phone 	7. Mobile
8. Email 	
9. Height cm	10. Weight kg
11. Marital status ☐ Married ☐ Defacto ☐ Single	12. Sex ☐ Male ☐ Female
13. Occupation 	14. Do you require an interpreter? ☐ No ☐ Yes ☐ Language

CLAIMANT DETAILS

15. Person claiming
☐ Worker ☐ Spouse/Defacto/Child ☐ Defacto – Attach a copy of at least one bill confirming the same residence.
☐ Child under 16 – Attach a copy of the child's birth certificate or Medicare card listing the child.
☐ Student over 16 – Attach a copy of the student's ID card.

Dependants means;

The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months), or the unmarried financially dependant children of the worker up to 16 years of age or up to 25 years of age if a full time student.

16. Name of person claiming (if not worker) 	17. Date of birth DD / MM / YYYY
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PLEASE ATTACH DOCUMENTATION

WORKER'S EMPLOYMENT DETAILS

18. Name of company 	19. Phone
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20. Date commenced

DD / MM / YYYY

21. Employment status

☐ Full-time
 ☐ Part-time
 ☐ Casual
 ☐ Apprentice
 ☐ Working Director
 ☐ Sub-Contractor

22. Are you still employed?

☐ Yes
 ☐ No

Date of termination DD / MM / YYYY

OTHER BENEFIT DETAILS

The Incolink Emergency Transport Program requires all ambulance claims to be lodged via the relevant Australian ambulance service or your private health insurer in the first instance.

23. Are you a Pension or Health Care card holder?

☐ No
 ☐ Yes

Card number

24. Do you have private health insurance?

☐ No
 ☐ Yes

Name of health fund

Membership number

Is Ambulance cover included?

☐ No
 ☐ Yes

You must submit the claim to your private health fund

AMBULANCE DETAILS

25. Date ambulance required

DD / MM / YYYY

26. Exact time ambulance required

HH : MM am / pm

27. Detail why an ambulance was required

PLEASE ATTACH ORIGINAL AMBULANCE INVOICE

28. Was the ambulance required as a result of a motor vehicle accident?

☐ No
 ☐ Yes

You must submit the claim to the appropriate statutory scheme

29. Was the ambulance required as a result of a work accident?

☐ No
 ☐ Yes

You must submit the claim to the appropriate statutory scheme

PAYMENT DETAILS

30. If this claim is accepted, how would you like to receive payment(s)

☐ Pay funds directly to Ambulance service

☐ Forward a cheque payable to myself

☐ Electronic Funds Transfer to myself

We depend on the accuracy of the details you provide.

Please attach proof of

- Account name
 - BSB / Account number
- to ensure correct details are entered for payment

Bank name

Account name

Account type

BSB

Account number

I (name in full) hereby authorise
Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.

Signature

Date DD / MM / YYYY

PLEASE ATTACH PROOF OF BANK DETAILS – FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT

DECLARATION AND AUTHORISATION

I hereby authorise any Australian Ambulance Service or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim. I authorise Total Claims Solutions to give or obtain information relating to my claim from any insurer and/or private health fund, statutory authorities, or their representatives. I authorise Total Claims Solutions to give or obtain information to my employer. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original. I understand that supplying false or misleading information will result in my right to compensation being forfeited. I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

I hereby declare that the information I have provided on this form is to the best of my knowledge and belief, true in every respect.

Signature

Print name

Date

DD / MM / YYYY

Total Claims Solutions manage the
Discretionary Ambulance Claims on behalf of Incolink

