



# Ambulance claim form

Your Policy number

## SECTION A: ADDITIONAL DETAILS

Please complete the following sections where applicable.

1. Are you entitled to compensation from any other source?  Yes  No
2. Did the need for Ambulance Transportation occur at work?  Yes  No
3. Did the need for Ambulance Transportation occur going to or from work?  Yes  No
4. Has a claim been lodged with your employer?  Yes  No
5. If No, do you intend to lodge a claim with your employer?  Yes  No
6. What is your occupation?
7. Are you self-employed?  Yes  No
8. Did the transport accident occur whilst travelling to or from work?  Yes  No
9. Do you intend to lodge a claim with the Transport Accident Commission or a Third Party Insurer?  Yes  No
10. Was the accident/injury the result of negligence or violence by another person?  Yes  No
11. Do you intend to lodge a claim against the Crimes Compensation Tribunal?  Yes  No
12. Do you intend to pursue a common law/personal injuries claim?  Yes  No

## SECTION E: DECLARATION

I **authorise** the Fund to contact any necessary persons if information is required to establish my entitlement to benefits.

I **declare** that information provided on this form is true, correct and complete and I will notify the Fund of any changes.

I **agree** to be bound by the Fund Rules.

Policyholder's signature

X

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MAIL TO: GPO Box 9809, Brisbane QLD 4001.

The Fund will only collect your personal information in order to respond to your enquiry and not disclose it to others. You may request access to this information.

For our Privacy Policy please call 133 234