

CLAIM FORM FOR “INJURY ON THE JOURNEY”

Supplementary information to be provided by a worker in respect of an injury received whilst on the daily or other periodic journey between the worker’s place of abode and place of employment or any trade technical or other training school.



PLEASE PRINT IN BLOCK LETTERS

Policy Number:

Claim Number:

About the Worker

Surname	First name	Date of Birth
Address		Postcode
Employer’s name		
Address		Postcode
Date and time of accident? Date / / . Time am/pm.		

About the Journey

What mode of transport were you using? (eg. on foot, car, bus)	
Where exactly did the accident occur? Street/Road	Suburb/Town
Were you travelling to or from work?	Following your usual route?
Were you travelling to or from trade or technical school?	Following your usual route?
Did you divert from your usual route?	Was the journey broken for any reason?
If so, for what reason?	
Had you consumed any alcohol or drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, how much?	

What Happened

How did the accident occur?
Names and Addresses of Witnesses.
In your opinion, who was responsible for the accident? And why?

NB If you were injured in a **Traffic Accident** please also complete the following questions. Please note that all traffic accidents must be reported to the police as soon as possible but no later than 28 days after the accident. If you have not, you should do so immediately.

About your Vehicle

Registration Number	State of registration
Driver’s name	Telephone
Address	Postcode
Owner’s name	Telephone
Address	Postcode

Other Vehicles Involved (If more than two vehicles, attach a separate list).

Registration Number	State of registration
Driver's name	Telephone
Address	Postcode
Owner's name	Telephone
Address	Postcode

About the Accident

Police station to which the accident was reported	Date reported
Police officer's name	Did police attend scene?
Police action taken or proposed	
If you were a passenger had the driver consumed any drugs or alcohol prior to the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, how much?	
If you were a driver/passenger were you wearing a seat belt?	
If you were a rider/passenger were you wearing a helmet?	

Using the symbols below draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows the directions of travel.

Your vehicle



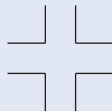
Other vehicle



Pedestrian, Cyclist, etc.



Intersection



I hereby declare that the foregoing statements are, to the best of my knowledge and belief, true and correct in every detail.

Signature of Claimant	Date
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Signature of Witness	Date
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