

SUPPLEMENTARY 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 or otherwise in the course of their employment.



PLEASE PRINT IN BLOCK LETTERS

CLAIM No.

ABOUT THE WORKER

Full name: _____ Date of birth: _____ (dd/mm/yyyy)
Address: _____
Employer's name: _____ Policy No. _____
Address: _____
Date and time of accident? Date: _____ Time: _____ : _____ AM PM

ABOUT THE JOURNEY

What mode of transport were you using? _____
Where exactly did the accident occur? Street / Road: _____ Suburb / Town: _____
Were you travelling "to" or "from" work? TO FROM Following your usual route? YES NO
Were you travelling "to" or "from" a trade or technical school? TO FROM Following your usual route? YES NO
Did you divert from your usual route? YES NO Was the journey broken for any reason? YES NO
If so, for what reason? _____
Had you consumed any alcohol or drugs? YES NO If "YES". How much? _____

WHAT HAPPENED

How did the accident occur?

Name and addresses of witnesses:
Full name: _____
Address: _____

ABOUT THE ACCIDENT If you were injured in a TRAFFIC ACCIDENT

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

TRAFFIC ACCIDENT DETAILS

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: _____
Address: _____ Telephone: _____
Owner's name: _____
Address: _____ Telephone: _____

OTHER VEHICLES INVOLVED (If more than two vehicles, attach a separate list).

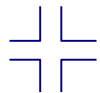
Registration number: _____ State of registration: _____
Driver's name: _____
Address: _____ Telephone: _____
Owner's name: _____
Address: _____ Telephone: _____

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

Your Vehicle  

Other Vehicle  

Pedestrian, Cyclist, etc.  



Intersection

COMMENTS

In your opinion, who was responsible for the accident? And why?

Have you claimed against person responsible: YES , NO . Name of Insurer: _____

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: _____

Witness to my Signature: _____ Date: _____