



Journey Accident Claim Form

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

Part A: Injured workers details

1. Full name:		Date of birth:	
2. Home address:		Postcode:	
3. Home phone:		Mobile:	
4. Name of employer:			
5. Address of employer:		Postcode:	

Part B: Journey accident details

6. Date of accident:		Time:		am/pm	
7. Usual starting time:		am/pm	Usual ceasing time:		am/pm
8. Exact time your journey commenced:				am/pm	
9. Mode of travel used:					
10. Was the injury sustained:					
(a) Travelling to or from your home and place of employment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, describe exactly where the accident happened:					
(b) Travelling to or from a place other than your normal place of employment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, what the purpose of the journey and who authorised the journey:					
11. Was this your normal route taken on date of accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
(a) Distance of journey:		Time usually taken:			
(b) Did you deviate/interrupt in any way from your usual route?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If so, provide reasons:					
12. How did the injury occur:					
13. Was there a connection between your work and the accident or incident that led to your injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, what was the connection:					
14. Did you consume any alcohol or drugs, including medication prior to the accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, provide details:					
15. Have you lodged any other claim as a result of this accident (e.g. property damage, CTP, public liability, etc...)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, specify type of claim, name of the insurer and claim reference number:					

Part C: Witnesses to accident

16. Were there any witnesses to the accident:		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, provide names and contact details below:			
Name	Address	Phone contact	

If a motor vehicle was involved please complete sections D-F.
 If no motor vehicle was involved please sign the declaration at the end of the form.

Part D: Traffic accident – vehicle you were travelling in

17. Registration number of the vehicle your where travelling in:			
18. Drivers name:		Licence:	
19. Drivers address:		Phone:	
20. Owners name:		Licence:	
21. Owners address:		Phone:	
22. Please describe the weather and road conditions:			

Part E: Traffic accident – other vehicle involved in accident
 (if more than one vehicle, please attach a separate list)

23. Registration number of the other vehicle:			
24. Drivers name:		Licence:	
25. Drivers address:		Phone:	
26. Owners name:		Licence:	
27. Owners address:		Phone:	
28. If you do not have the other drivers details or vehicle registration:			
(a) Provide reasons why (e.g. did the other driver leave the scene of the accident):			
(b) What attempts have you made to identify the other driver:			
(c) Describe other vehicle involved (e.g. colour make model or any distinguishing marks or observations):			

Part F: Reporting and locality

29. Was the incident reported to the police?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, name of police station:			
30. Date reported:		Police Event Number:	
31. Name of party responsible for accident:			

I hereby declare that the information in this claim form is to my knowledge and belief true and correct:

Claimant signature:		Date:	
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