

Claim Number	
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PLEASE PRINT IN BLOCK LETTERS

'JOURNEY INJURY' CLAIM FORM
Supplementary information to be provided by a claimant in respect of an injury received whilst on the daily or periodic journey between the claimant's residence and place of employment or any trade, technical or other training school.

StateCover Mutual Limited ABN:36 090 394 755 PO Box Q409 QVB Post Office SYDNEY NSW 1230 Tel: (02) 8270 6000 Fax: (02) 9262 6605

CLAIMANT DETAILS

Title Surname	Address		
Given Name/s	Suburb	State	Postcode
Date of Birth: / / Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No.		

EMPLOYER DETAILS

Council	Workplace name and location where you are usually employed (eg. depot, branch, etc.)
Address	
Suburb State Postcode	

ABOUT THE JOURNEY

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

Note: If you were involved in a traffic accident please complete the questions on the next page.

TRAFFIC ACCIDENT DETAILS

(All traffic accidents should be reported to police as soon as possible but no later than 28 days after the accident)

ABOUT YOUR VEHICLE

Registration No:		State of registration:	
Driver's Name:		Telephone:	
Date of Birth:		Licence No:	
Address:	Suburb:	State:	Postcode:
Owner's Name:		Telephone:	
Address:	Suburb:	State:	Postcode:


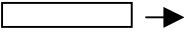

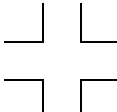
OTHER VEHICLES INVOLVED (IF MORE THAN ONE ATTACH A SEPARATE DETAILED LIST)

Registration No:		State of registration:	
Driver's Name:		Telephone:	
Date of Birth:		Licence No:	
Address:	Suburb:	State:	Postcode:
Owner's Name:		Telephone:	
Address:	Suburb:	State:	Postcode:

ABOUT THE ACCIDENT

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

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

- Your vehicle 
- Other vehicle 
- Pedestrian cyclist 
- Intersection 

I declare that the information given in this form is, to the best of my knowledge, true and correct in every detail.

Signature of claimant:	Date:
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Signature of witness:	Date:
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