FORM 3

PERSONAL INJURIES PROCEEDINGS ACT 2002

NOTICE OF CLAIM
(Dependency Claims)

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ATTACHED AS THE LAST THREE PAGES OF THE FORM

PLEASE READ INSTRUCTIONS CAREFULLY

THERE ARE TWO PARTS TO THIS FORM

PART 1 AND PART 2 ARE TO BE GIVEN AT DIFFERENT TIMES

This Notice of Claim has been approved by the Department of Justice and Attorney-General and questions etc. should not be altered in any way

Version 3

NOTICE OF CLAIM
(Dependency Claims)

PART 1
(Comprising Sections A, B and C)

To: _____

_____

_____

_____
(Respondent/s – Name/s and Address/es)

NOTICE TO RESPONDENT

Within one (1) month after receiving Part 1 of this Notice, you must:

(a) if you consider yourself a proper respondent to the claim, give the claimant written notice of whether you are satisfied that the Part 1 Notice of Claim is a complying Part 1 Notice of Claim and if not, give details of non-compliance and whether you waive that non-compliance. If you do not waive non-compliance, you must specify a reasonable period of at least 1 month for the claimant to remedy the non-compliance;

(b) if you are unsure whether you are a proper respondent to the claim, give the claimant written notice of the further information you reasonably need to decide whether you are a proper respondent; or

(c) if you consider that you are not a proper respondent to the claim, give the claimant written notice of the reasons why you consider that you are not a proper respondent to the claim and any information you have that may help the claimant identify a proper respondent to the claim.

In any of the above responses, you should provide the claimant with the name and telephone number of a contact person who will be dealing with the claim.

DEPENDENCY CLAIMS

[Section A]

Initial Claim Details

(to be completed by the primary person making a claim as either a relative/ dependant/guardian/executor, on behalf of all dependants, for loss resulting from a person sustaining a fatal injury)

1. CLAIMANT'S PERSONAL DETAILS

Surname/Family Name: _____

Given Names: _____

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Date of Birth: _____ *(insert day/month/year)*

Gender: ☐ Male ☐ Female

Home Address: _____

_____ Postcode: _____

Postal Address (*if different than above*): _____

_____ Postcode: _____

Home Telephone Number: (____) _____

2. DECEASED PERSON'S PERSONAL DETAILS

Surname/Family Name: _____

Given Names: _____

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Date of Birth: _____ *(insert day/month/year)*

Gender: ☐ Male ☐ Female

Home Address: _____

_____ Postcode: _____

3. RELATIONSHIP

Did you reside with the deceased? ☐ No ☐ Yes

What was your relationship to the deceased?

☐ Spouse (including de facto partner) *(tick and go to Q4)*

☐ Dependant (including claim on behalf of dependant, e.g. guardian, etc.) *(tick and got to Q5)*

☐ Other _____(provide detail) *(tick and got to Q5)*

4. SPOUSE(including de facto partner)

Give details of:

Date of Marriage: _____

Place of Marriage: _____

Date your de facto relationship commenced: _____ *(insert day/month/year)*

(Note: acceptable evidence of your relationship may be required)

5. OTHER DEPENDANTS (all dependency claimants are to be nominated in the one Notice of Claim form)

Details of other dependant persons:
Complete the following details for all dependant children and other dependant persons not included as the primary claimant above.

Dependant 1:
Surname/Family Name: _____

Give Names: _____

Date of Birth: _____ *(insert day/month/year)*

Marital Status: ☐ Single ☐ Married ☐ De facto

Gender: ☐ Male ☐ Female

Relationship to Deceased: _____

Did the dependant reside with the claimant?

☐ Yes

☐ No Home Address: _____

_____

Home Telephone Number: (____) _____

Dependant 2:
Surname/Family Name: _____
Give Names: _____

Date of Birth: _____ *(insert day/month/year)*

Marital Status: ☐ Single ☐ Married ☐ De facto

Gender: ☐ Male ☐ Female

Relationship to Deceased: _____

Did the dependant reside with the claimant?

☐ Yes

☐ No Home Address: _____

_____

Home Telephone Number: (____) _____

Dependant 3:
Surname/Family Name: _____

Give Names: _____

Date of Birth: _____ *(insert day/month/year)*

Marital Status: ☐ Single ☐ Married ☐ De facto

Gender: ☐ Male ☐ Female

Relationship to Deceased: _____
Did the dependant reside with the claimant?

☐ Yes

☐ No Home Address: _____

_____

Home Telephone Number: (____) _____

Dependant 4:
Surname/Family Name: _____

Give Names: _____

Date of Birth: _____ *(insert day/month/year)*

Marital Status: ☐ Single ☐ Married ☐ De facto

Gender: ☐ Male ☐ Female

Relationship to Deceased: _____

Did the dependant reside with the claimant?

☐ Yes

☐ No Home Address: _____

_____

Home Telephone Number: (____) _____

(If there are insufficient spaces for all Dependants, please provide the further details for each further dependant upon an attached page/s labelled "Dependant's Details".)

6. HAS THE INJURED PERSON INSTRUCTED A LAW PRACTICE TO ACT ON THE PERSON'S BEHALF IN SEEKING DAMAGES FOR THE PERSONAL INJURY?

☐ No ☐ Yes - Date of Consultation: _____ *(insert day/month/year)*

Name of Lawyer and Firm: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

7. DOES THE CLAIMANT NEED AN INTERPRETER?

☐ No ☐ Yes

If 'Yes', which language will the interpreter need to be fluent in?

_____

8. HAS THE CLAIMANT GIVEN, OR DO THEY INTEND TO GIVE, NOTICES OF CLAIM TO ANY OTHER PERSON IN RELATION TO THE INCIDENT?

☐ No ☐ Yes

If yes, give full details of the names and addresses of each other person to whom they have given or intend to give a Notice of Claim:

(i) _____

(ii) _____

(iii) _____

(iv) _____

9. IS THE STATE OF QUEENSLAND THE RESPONDENT NAMED IN THIS NOTICE OF CLAIM?

☐ No ☐ Yes

If Yes, which is the government department you believe to be responsible?

_____

[Section B]

THE INCIDENT

- **All claimants are required to complete Subsection 1 of this section of the form.**
- **Only claimants that relate to health care claims are required to answer Subsection 2 of the section.**
- **Claimants that relate to non-health care claims are required to answer Subsection 3 of the section.**

Subsection 1 – All Claimants to Complete

10. GENERAL DETAILS

Date of Incident: _____ *(insert day/month/year)*

Time of Incident: ____ ☐ am ____ ☐ pm

Place where the incident occurred (hospital or other facility or, where applicable, street and town or suburb) _____

11. GIVE A BRIEF DESCRIPTION OF THE INCIDENT

_____

_____

_____

_____

_____

_____

_____

12. WHAT INJURIES DID THE DECEASED PERSON SUSTAIN IN THE INCIDENT THAT THE DEATH IS ATTRIBUTABLE TO?

List all injuries: _____

_____

_____

_____

13. WITNESSES

Give Details of Witnesses present at the incident/time of death:

Witness 1:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (_____) _____

Witness 2:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (_____) _____

(Note: If more than two witnesses, write the details on a separate page labelled 'Witnesses' and attach it to this form)

14. IN THE 12 HOURS BEFORE THE INCIDENT, HAD THE DECEASED PERSON TAKEN ANY DRUGS (INCLUDING PRESCRIBED MEDICATION BUT NOT DRUGS PRESCRIBED FOR TREATMENT RESULTING IN A HEALTH CARE CLAIM)?

☐ No ☐ Yes ☐ Don't know

What drugs were taken?: _____ *(insert type)*

_____ *(insert amount)* _____ *(insert when)*

15. IN THE 12 HOURS BEFORE THE INCIDENT HAD THE DECEASED PERSON CONSUMED ANY ALCOHOL?

☐ No ☐ Yes ☐ Don't know

What drinks were consumed? _____ *(insert type)*

_____ *(insert amount)* _____ *(insert when)*

16. DETAILS OF THE PERSON(S) THAT CAUSED THE DEATH.

Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

17. DETAIL THE REASONS WHY THE CLAIMANT BELIEVES THAT PERSON CAUSED THE DEATH

The reasons must particularly identify the step, process or act/s of the person that caused the death of the deceased and the link to the named Respondent (if different to the person named in response to Q16): _____

_____

_____

_____

_____

_____

(Note: If more than one person caused the incident, please write details and reasons on a separate page labelled, 'Persons that caused the incident' and attach it to this form.)

18. HAD THE DECEASED PERSON SUFFERED ANY PERSONAL INJURIES, ILLNESSES OR DISABILITIES BEFORE THE INCIDENT THAT MAY AFFECT THE AMOUNT OF DAMAGES IN ANY WAY?

☐ No ☐ Yes

If 'Yes', Date: _____ *(insert day/month/year)*

Doctors: _____

_____

Hospital: _____

Nature of injuries, illnesses or disabilities _____

_____

_____

---

19. PROVIDE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE PROVIDED THE CLAIMANT WITH INFORMATION OR EXPLANATIONS ABOUT THE INCIDENT OR DEATH.

Person 1:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

Person 2:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

Person 3:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

(Note: If more than three persons have provided information or explanations, please write details on a separate page labelled, 'Persons Providing Information or Explanation' and attach it to this form.)

IF THE CLAIM RELATES TO A DEATH ARISING FROM HEALTH CARE, COMPLETE SUBSECTION 2 OF THIS SECTION (pages 12-14) AND THEN MOVE TO SECTION C OF THE FORM (page 20).

IF THE CLAIM RELATES TO AN INCIDENT NOT RELATED TO HEALTH CARE, COMPLETE PART 3 OF THIS SECTION (pages 15-19) AND THEN MOVE TO SECTION C OF THE FORM (page 20).

Subsection 2 – Claimants Relating to Health Care Claims Only to Complete

20. DOES THE CLAIMANT ALLEGE that the CLAIM RELATES TO OR INCLUDES AN ALLEGED FAILURE OF THE HEALTH CARE PROVIDER TO INFORM OR ADEQUATELY INFORM THE DECEASED OF THE RISKS INVOLVED IN THE TREATMENT SOUGHT?

☐ No *(if no, tick and go to Q21)* ☐ Yes ☐ Don't know

(i) If yes, provide the date, time and place of each consultation with the health care provider in which a warning should have been given:

_____

_____

(ii) If the health care provider did provide any advice or a warning about the treatment, in relation to each instance where such advice or warning was given, identify –

- Whether that advice or warning was given orally or in writing?

_____

_____

- The date and place where each advice or warning was given?

_____

_____

- Details of the warning given, including what you were warned about?

_____

_____

(iii) What were the risks about which it is alleged the deceased should have been informed or adequately informed by the health care provider?

_____

_____

21. WAS WRITTEN OR ORAL CONSENT GIVEN BY THE DECEASED PERSON TO THE HEALTH CARE PROVIDER ABOUT THE TREATMENT?

☐ No

☐ Yes_____ *(insert date)* _____*(insert time)*

_____ *(insert place)*

_____

_____

_____

(insert details of the consent)

22. HAS A COMPLAINT ABOUT THE PERSON WHOM THE COMPLAINANT BELIEVES CAUSED THE DEATH BEEN MADE TO THE HEALTH RIGHTS COMMISSION?

☐ No *(if no, tick and go to Q23)* ☐ Yes ☐ Don't know

(a) Give the date the complaint was made to the Commission: _____

(b) Has the complaint been finalised under the *Health Rights Commission Act 1991?* ☐ No ☐ Yes

If 'Yes', give details of how the complaint was dealt with under that Act:

_____

_____

_____

Date the complaint was finalised: _____

23. DESCRIBE THE MEDICAL CONDITION FOR WHICH THE DECEASED PERSON SOUGHT TREATMENT:

_____

_____

24. DESCRIBE WHAT ASPECT OF THE TREATMENT IS BEING COMPLAINED OF AS CAUSING THE DEATH: _____

_____

_____

_____

25. PROVIDE THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL HEALTH CARE PROVIDERS WHO TREATED THE DECEASED PERSON FOR THE MEDICAL CONDITION FOR WHICH TREATMENT WAS SOUGHT DURING THE THREE (3) YEARS PRIOR TO THE INCIDENT.

Provider 1:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Provider 2:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Provider 3:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Provider 4:

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

(Note: If more than four providers were involved in the incident, please write details on a separate page labelled, 'Health Care Providers prior to the Incident' and attach it to this form.)

GO TO SECTION C – PAGE 20

Subsection 3 – Claimants Relating to Non-Health Care Claims to Complete.

26. FURTHER GENERAL INCIDENT DETAILS

Weather conditions at the time of the incident:

_____

Did an emergency response entity or an investigative entity come to the scene of the incident? (eg. police, fire authority, ambulance)

☐ No *(if no, tick and go to Q27)* ☐ Yes

Did the deceased person need an ambulance?

☐ No ☐ Yes Officer's Name: _____

Station: _____

Contact Details (if known):
Reference No. (if known):

Did the fire authority attend?

☐ No ☐ Yes Officer's Name: _____

Station: _____

Contact Details (if known):
Reference No. (if known):

Did the police attend?

☐ No ☐ Yes Officer's Name: _____

Station: _____

Contact Details (if known):
Reference No. (if known):

Did another entity attend (*eg. Surf lifesavers, SES*)?

☐ No ☐ Yes Entity/Officer's Name: _____

Station/Location: _____

Contact Details (if known):
Reference No. (if known):

27. WHAT WAS THE DECEASED PERSON'S PART IN THE INCIDENT? (DESCRIBE WHAT THE DECEASED PERSON WAS DOING)

_____

_____

_____

_____

28. WAS A PROTECTIVE DEVICE AVAILABLE FOR USE, E.G. SAFETY HARNESS, SAFETY GOGGLES?

☐ No ☐ Yes

If 'No', go to Q30

If 'Yes', what was the device?

_____

29. WAS THE DECEASED PERSON WEARING/USING THE PROTECTIVE DEVICE AT THE TIME OF THE INCIDENT?

☐ No ☐ Yes

30. IF POSSIBLE, DRAW A DIAGRAM OF THE INCIDENT, INCLUDING DETAILS OF LOCATION SUCH AS STREET NAMES (ATTACH ON A SEPARATE PIECE OF PAPER)

31. DETAILS OF ANY OTHER PERSON(S) INVOLVED IN THE INCIDENT

Person 1:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Person 2:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Person 3:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Person 4:
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

(Note: If more than four persons were involved in the incident, please write details on a separate page labelled, 'Persons involved in the incident' and attach it to this form.)

32. DID THE DECEASED PERSON GO TO HOSPITAL?

☐ No *(if no, tick and go to Q34)*

☐ Yes Hospital: _____

Address: _____

_____

Date: _____ (insert day/month/year)

33. WAS THE DECEASED PERSON ADMITTED TO HOSPITAL?

☐ No

☐ Yes Hospital: _____

Address: _____

_____

Date: _____ *(insert day/month/year)*

34. WHO ATTEMPTED TO TREAT THE DECEASED PERSON FOR THEIR INJURIES AND WHAT TREATMENT WAS PROVIDED (if known)?

List all health care providers, eg doctors, surgeons, physiotherapists, chiropractors and fully detail the treatment provided (eg. surgical placement of pins; psychiatric assessment, etc)

Provider 1:

Occupation: _____

Name (practice or surgery): _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

Provider 2:

Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

Provider 3:

Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

Provider 4:

Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

(Note: If not enough space, write details on a separate page labelled 'Health Care Providers etc' and attach it to this form.)

[Section C]

DOCUMENTS THAT SHOULD BE ATTACHED TO THIS FORM

Please attach a copy of each the following to the rear of this form:
(*please tick if attached***)**

- ❑ **death certificate**
- ❑ **medical reports relating to the incident**
- ❑ **written health care warnings/advices (health care claimants only)**
- ❑ **reports generally relating to the incident and its causes**
- ❑ **medical reports relating to the history of the deceased**
- ❑ **a diagram of the incident (non-health care claims only)**

DECLARATION AND AUTHORISATION

(All Claimants are to complete this section)

You must have completed all of the information required in this Notice of Claim and must declare the content as true before a Justice of the Peace or Solicitor.

The form must be signed by the claimant unless he/she is under 18 or is unable to complete it. In these cases it must be completed by a parent, guardian, relative or legal friend of the claimant.

You must also give your written permission to allow the respondent or their insurer to obtain any records or information that may affect your claim from:

- The insurers;
- A department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
- A hospital;
- The ambulance or other emergency service of the State or another State;
- A doctor or other health-care provider;
- An educational institution;
- An employer (or previous employer).

Under Section 73 of the *Personal Injuries Proceedings Act 2002* you can be fined up to $11,250 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information you have given in the Notice of Claim must be true, correct and complete.

Claimant's Authorisation and Declaration

I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within this claim and to obtain information and documents relevant to the claim.

I do solemnly and sincerely declare that the statements of fact contained in this Notice of Claim (Dependency Claim) (including the attached pages) are true, correct and complete in every respect and I make this declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

_____

(Signature)

TAKEN AND DECLARED BEFORE ME: _____

(Signature of Justice of the Peace or Solicitor)

ON: _____ / _____ / _____

AT (*plac*e): _____

Justice of the Peace or Solicitor's Name: _____

Address: _____

Claimant's Surname/Family Name:_____

Given Names: _____

IF ANOTHER PERSON SIGNED ON BEHALF OF THE CLAIMANT:

Give Details of the Person who Signed the Form:

Person's Surname/Family Name:_____

Given Names: _____

Address: _____

_____

Home Telephone Number: (_____) _____

Relationship to the Claimant: _____

Reason/s why the Claimant could not sign: _____

NOTICE OF CLAIM
(Dependency Claims)

PART 2
(Comprising Sections D, E, F and G)

To: _____

_____

_____

_____
(Respondent/s – Name/s and Address/es)

From: _____

_____

_____

_____
(Claimant)

Deceased: _____

[Section D]

Claimant's and Dependants' Health & Financial Details

35. CLAIMANT'S EDUCATIONAL DETAILS
Names of educational institutions and years attended by you:

(i) _____

(ii) _____

(iii) _____

(iv) _____

ARE YOU A FULL TIME STUDENT? ☐ No ☐ Yes

36. CLAIMANT'S EMPLOYMENT DETAILS

Usual occupation:

Are you currently employed? ☐ No ☐ Yes

If 'Yes', give details of:

Nature of Employment:

Name of Employer (Company or Organisation): _____

_____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

Contact person: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax Amount)*

_____ *(insert Net Pay)*

Do you have any other source of income? ☐ No ☐ Yes

Nature of Separate Source of Income: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax Amount)*

_____ *(insert Net Pay)*

37. DOES THE CLAIMANT SUFFER FROM ANY SERIOUS MEDICAL CONDITION OR DISABILITY?

☐ No ☐ Yes

Give Details: _____

_____

38. WHAT WERE THE AVERAGE WEEKLY PAYMENTS AND/OR OTHER FINANCIAL BENEFITS PROVIDED TO THE CLAIMANT BY THE DECEASED PRIOR TO THE INCIDENT?

_____

_____

_____

39. CLAIMANTS'S CLAIMS HISTORY

(a) Have you ever made a claim for damages for a personal injury?

☐ No ☐ Yes

(b) In respect of personal injury, illness or disability (or its symptoms) that existed for a period of more than four (4) weeks, have you (or the deceased) ever:

- made a claim for damages, social security benefits or compensation?

  ☐ No ☐ Yes
- received any amount by way of damages, social security benefits or compensation?

  ☐ No ☐ Yes

If 'Yes' to any question in 1(a) or 1 (b), please provide the details of:

The Injury/Illness/Disability: _____

_____

_____

The Damages: _____

_____

_____

The Benefit and/or Compensation: _____

_____

_____

40. OTHER DEPENDANTS DETAILS (all dependency claimants are to be nominated in the one Notice of Claim form)

Details of other dependant persons:
Complete the following details for all dependant children and other dependant persons not included as the primary claimant above.

Dependant 1:
Surname/Family Name: _____

Give Names: _____

Full Time Student? ☐ No ☐ Yes

Education Details: _____ *(insert institution/school)*

_____ *(insert qualifications)*

Does the Dependant have any Separate Source of Income?

☐ No ☐ Yes

Nature of Separate Source of Income: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____*(insert Tax Amount)*

_____ *(insert Net Pay)*

Dependant 2:
Surname/Family Name: _____
Give Names: _____

Full Time Student? ☐ No ☐ Yes

Education Details: _____ *(insert institution/school)*

_____ *(insert qualifications)*

Does the Dependant have any Separate Source of Income?

☐ No ☐ Yes

Nature of Separate Source of Income: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____*(insert Tax Amount)*

_____ *(insert Net Pay)*

Dependant 3:
Surname/Family Name: _____

Give Names: _____

Full Time Student? ☐ No ☐ Yes

Education Details: _____ *(insert institution/school)*

_____ *(insert qualifications)*

Does the Dependant have any Separate Source of Income?

☐ No ☐ Yes

Nature of Separate Source of Income: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____*(insert Tax Amount)*

_____ *(insert Net Pay)*

Dependant 4:
Surname/Family Name: _____

Give Names: _____

Full Time Student? ☐ No ☐ Yes
Education Details: _____ *(insert institution/school)*

_____ *(insert qualifications)*

Does the Dependant have any Separate Source of Income?

☐ No ☐ Yes

Nature of Separate Source of Income: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____*(insert Tax Amount)*

_____ *(insert Net Pay)*

(If there are insufficient spaces for all Dependants, please provide the further details for each further dependant upon an attached page/s labelled "Dependant's Details".)

41. DO ANY OF THE DEPENDANTS SUFFER FROM ANY SERIOUS MEDICAL CONDITION OR DISABILITY?

☐ No ☐ Yes

Provide full details:

Name of Dependant: _____

Nature of the Health Problem: _____

_____

42. WHAT WERE THE AVERAGE WEEKLY PAYMENTS AND/OR OTHER FINANCIAL BENEFITS PROVIDED TO EACH OF THE ABOVE NAMED DEPENDANTS BY THE DECEASED PRIOR TO THE ACCIDENT?

Dependant 1 (Weekly Payment/Benefit): _____

Dependant 2 (Weekly Payment/Benefit): _____

Dependant 3 (Weekly Payment/Benefit): _____

Dependant 4 (Weekly Payment/Benefit): _____

43. HAS THE CLAIMANT OR ANY DEPENDENT APPLIED FOR OR RECEIVED ANY MONEY OR BENEFIT ARISING OUT OF THE INCIDENT? FOR EXAMPLE, SOCIAL SECURITY BENEFITS, WORKER'S COMPENSATION, BORROWED MONEY OR INSURANCE PAYMENT.

☐ No ☐ Yes

Give full details (including amounts) if :

(a) social security benefit (give your social security reference number): _____Amount: $

(b) workers' compensation (give the insurer's details and claim number):

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Claim Number: _____

Amount:$

(c) borrowed money (give the lender's details):

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Amount: $

(d) payment from an insurance company, give the name and address of the insurer and the policy number.

Name: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____
Amount: $

[Section E]

THE DECEASED

(All Claimants are required to complete this section. All of the information required herein must relate to the deceased person).

44. DECEASED PERSON'S EDUCATIONAL DETAILS

Names of educational institutions (including the years) attended by the deceased person:

(i) _____

(ii) _____

(iii) _____

(iv) _____

45. HAS THE DECEASED PERSON EVER BEEN KNOWN BY ANY OTHER NAME?

☐ No ☐ Yes

If 'Yes', provide in full, all other names the person has been known by:

_____

_____

46. HAD THE DECEASED PERSON EVER MADE A CLAIM BEFORE THE INCIDENT IN RELATION TO THIS OR ANY OTHER INCIDENT FOR DAMAGES, COMPENSATION OR SOCIAL SECURITY BENEFITS RESULTING FROM PERSONAL INJURIES, ILLNESSES OR DISABILITIES?

☐ No

☐ Don't know

☐ Yes Date: _____ *(insert day/month/year)*

What was the injury?

Against whom was the claim made?

Name: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Name of Insurer:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Claim Reference No.: _____

Type of Claim (eg Workers' Compensation): _____

_____

(NOTE: If the deceased person has made more than one claim, write details on a separate page labelled 'Previous Claims' and attach it to this form.)

47. WHAT WAS THE DECEASED PERSON'S EMPLOYMENT SITUATION BEFORE THE INCIDENT?

☐ Self-employed ☐ Retired

☐ Home duties ☐ Student

☐ Employed ☐ Other *(please describe)*

☐ Unemployed _____

Usual Occupation: _____

Was the deceased person employed as at the date of death? ☐ No ☐ Yes

Nature of Employment:

_____

_____ *(insert details)*

48. DID THE DECEASED PERSON USE AN ACCOUNTANT IN PREPARATION OF TAXATION RETURNS, BUSINESS STATEMENTS, OR SIMILAR FINANCIAL DOCUMENTS?

☐ No ☐ Yes

Accountant's Details (if applicable):

Accountant's Name: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

49. LIST HERE PARTICULARS OF THE DECEASED PERSON'S EMPLOYMENT DURING THE THREE (3) YEARS PRIOR TO THE INCIDENT *(if self-employed see below.) (Attach additional information on a separate page/s if required.)*

Name of Employer:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Period of Employment: _____

Capacity in which Employed: _____

Earnings for Period: _____

Self Employed Details: ***(if applicable)***

Period Self-employed: _____

Gross Earnings per year: _____

Net Earnings per year: _____

Name of Business:_____

Nature of Business: _____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

IF THE DECEASED PERSON WAS SELF-EMPLOYED IMMEDIATELY PRIOR TO THE INCIDENT, GO TO QUESTION 50.

IF THE DECEASED PERSON WAS <u>NOT</u> SELF-EMPLOYED IMMEDIATELY PRIOR TO THE INCIDENT, GO TO QUESTION 53.

50. ESTIMATED EARNINGS LOST

Give details of how much it is believed the deceased person was earning **through self employment** at the date of death and how the amount is calculated. *(Copies of the deceased person's taxation returns <u>must</u> be provided to the respondent.)*

_____

_____

_____

(Note: If necessary, write details on a separate page labelled 'Self Employment Earnings Lost' and attach it to this form.)

51. IS THE BUSINESS STILL OPERATING?

☐ No ☐ Yes

52. HAS ANYONE BEEN HIRED TO REPLACE THE DECEASED PERSON?

☐ No Explain why not: _____

_____

☐ Yes Give details of replacement:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Duties Performed: _____

Cost: _____

(Note: If necessary, write details on a separate page labelled 'Self Employment – Replacement' and attach it to this form.)

53. EMPLOYMENT DETAILS (as at date of death)

(*If the deceased person was not an employee, go directly to Q56*)
Occupation: _____

Name of Employer (Company or Organisation): _____

_____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

Contact Person's Name: _____

Usual **Weekly** Working hours: _____ (ordinary) _____ (overtime)

Description of Duties: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax amount)*

_____ *(insert Net Pay)*

54. DID THE DECEASED PERSON HAVE A SECOND EMPLOYED JOB IMMEDIATELY BEFORE THE INCIDENT?

☐ No *(if no, tick and got to Q56)* ☐ Yes *(go to Q55)*

55. EMPLOYMENT DETAILS – SECOND JOB

Second Job:

Employment Details:_____

Occupation: _____

Name of Employer (Company or Organisation): _____

_____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

Contact Person's Name: _____

Usual **Weekly** Working hours: _____ (ordinary) _____ (overtime)

Description of Duties: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax amount)*

_____ *(insert Net Pay)*

(If the deceased person held further employed positions as at the date of death, provide details of these upon a separate page headed "Employed Positions Held")

56. WAS THE DECEASED PERSON AWAY FROM WORK FOR ANY SEPARATE PERIODS OF TIME BECAUSE OF THE INCIDENT? (*include short periods when they went for treatment*) (*this question is only relevant in instances where the deceased returned to work after the incident which the claimant alleges resulted in the death of the deceased person*)

☐ No ☐ Yes

Separate Periods:

First (or only)Period: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

Second Period *(if applicable)*: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

(Note: If the deceased person had more than two separate periods away from work, write details on a separate page labelled 'Periods Away from Work' and attach it to this form.)

57. BEFORE THE INCIDENT, HAD THE DECEASED PERSON MADE ANY FIRM ARRANGEMENTS TO START A NEW JOB, OR STOP WORK, OR CHANGE THEIR DUTIES, WORKING HOURS, OR EARNINGS?

☐ No ☐ Yes

Give Details: _____

_____

(Please attach any supporting documents relating to this change.)

58. DID THE DECEASED PERSON RECEIVE ANY MONEY FOR BEING UNABLE TO WORK BECAUSE OF THEIR INJURIES? (*e.g., sick leave or holiday pay, social security benefits, workers' compensation, borrowed money or insurance payment*.)

☐ No ☐ Yes

Give Full Details (inc. amount): $_____

_____

If the deceased:

(a) received a benefit provide their social security number: _____

(b) received workers' compensation, provide the insurer's details and claim number:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Claim Number: _____

(c) borrowed money, provide the lender's details:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

(d) received a payment from an insurance company, provide the name and address of the insurer and the policy number.

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Policy Number: _____

[Section F]

SETTLEMENT AND PARTIES

(All claimants are to complete this section.)

59. AT THIS STAGE, IS THE CLAIMANT IN A POSITION TO MAKE AN OFFER FOR THE SETTLEMENT OF THE CLAIM?

☐ No - Provide the reason/s why an offer of settlement cannot be made:

_____

_____

_____

☐ Yes - Provide full details of the basis of the offer of settlement:

_____

_____

_____

NOTE: An offer of settlement <u>must be</u> accompanied by a copy of medical reports, assessments of cognitive, functional or vocational capacity, or other material in their possession that may assist the respondent to make a proper assessment of the offer.

[Section G]

DOCUMENTS THAT SHOULD BE ATTACHED TO THIS FORM

Please attach a copy of each the following to the rear of this form:
(*please tick if attached***)**

- ❑ **taxation returns of the claimant dependant (for the three years prior to the incident)**
- ❑ **taxation returns of all other dependants (for the three years prior to the incident)**
- ❑ **taxation returns of the deceased person (for the three years prior to the incident)**
- ❑ **medical reports relating to the dependants**
- ❑ **reports generally relating to the incident and its causes not previously provided to the respondent**

DECLARATION AND AUTHORISATION

(All Claimants are to complete this section)

You must have completed all of the information required in Part 2 of this Notice of Claim and must declare the content as true before a Justice of the Peace or Solicitor.

The form must be signed by the claimant unless he/she is under 18 or is unable to complete it. In these cases it must be completed by a parent, guardian, relative or legal friend of the claimant.

You must also give your written permission to allow the respondent or their insurer to obtain any records or information that may affect your claim from:

- The insurers;
- A department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
- A hospital;
- The ambulance or other emergency service of the State or another State;
- A doctor or other health-care provider;
- An educational institution;
- An employer (or previous employer).

Under Section 73 of the *Personal Injuries Proceedings Act 2002* you can be fined up to $11,250 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information you have given in the Notice of Claim must be true, correct and complete.

Claimant's Authorisation and Declaration

I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within this Part 2 Notice of Claim and to obtain information and documents relevant to the claim.

I do solemnly and sincerely declare that the statements of fact contained in this Part 2 Notice of Claim (Dependency Claim) (including the attached pages) are true, correct and complete in every respect and I make this declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

_____

(Signature)

TAKEN AND DECLARED BEFORE ME: _____

(Signature of Justice of the Peace or Solicitor)

ON: _____ / _____ / _____

AT (*plac*e): _____

Justice of the Peace or Solicitor's Name: _____

Address: _____

Claimant's Surname/Family Name:_____

Given Names: _____

IF ANOTHER PERSON SIGNED ON BEHALF OF THE CLAIMANT:

Give Details of the Person who Signed the Form:

Person's Surname/Family Name:_____

Given Names: _____

Address: _____

_____

Home Telephone Number: (_____) _____

Relationship to the Claimant: _____

Reason/s why the Claimant could not sign: _____

INSTRUCTIONS TO CLAIMANT FOR COMPLETING THIS FORM

What you need to do -

- Use this form **if you personally were a relative/dependant of a person who died** due to the fault of another person.

AND/OR

- Use this form **on behalf of a person/s who were dependant upon a person who died** and who is unable to personally complete the information.

- **Give your written notice of claim as soon as possible**. Your claim could be rejected if the respondent receives Part 1 of the Notice past the earlier of the following two dates:

    - the day **nine (9) months** after the day of the incident or the first appearance of symptoms of the injury.

    - the day **one (1) month after you first instructed a law practice** to act on your behalf in seeking damages for the personal injury.

- **Keep a copy of the completed form** and any other papers included in your claim so that you have your own record.

- **You can negotiate with the respondent** and settle the claim yourself. It is important for you to know your rights. You could have a dispute with the respondent about the amount payable to you. If you are unsure what to do, a solicitor can advise you what needs to be done and how much it will cost.

- **Tear off these three pages of instructions and keep them**. They will be useful as a reminder of what you need to do, and also what you can expect to happen with your claim.

The person at fault

It is **essential** that you name the person or persons you regard at fault in the incident (see question 16) - that is, the person you believe caused the incident – and the reasons why (see question 17).

You must provide each person at fault with a Notice of Claim.

You must place the name and address of the respondent who you are giving the notice to on both Parts 1 and 2 of the Notice of Claim. If the Respondent is the State of Queensland, you must nominate the government Department you consider responsible.

STEPS TO COMPLETE THIS FORM

STEP 1

Please use a black or blue pen and print clearly or type your answers into the form. Start from question 1 and work your way through Part 1 of the form carefully, following the 'go to' instructions. **The Form is in sections, and you may not need to complete each one.**

Attach separate pages with any further information if there is not enough space on the form.

You must answer questions truthfully and answers must be complete as far as you know or can reasonably find out.

Severe penalties apply where false or misleading information is given.

The statements of fact contained in this notice of claim must be true, correct and complete and be signed in the presence of a Justice of the Peace or a Solicitor.

***Before you sign the form read it carefully,* as the declaration of fact at the end of the form is to be made in accordance with the Oaths Act 1867.**

STEP 2

Give Part 1 your notice of claim to the person whom you believe caused the incident so that it is received no later than **nine (9) months** after the date of the incident or first symptoms of injury or within **one (1) month** of instructing a law practice to act on the your behalf in seeking damages for the personal injury (whichever is the earlier).

If you believe the **State of Queensland <u>caused</u>** the incident, then the Notice of Claim must nominate the Government Department which you believe caused the incident and be delivered to:

Crown Law
Level 11
State Law Building
50 Ann Street
BRISBANE QLD 4000

Facsimile: (07) 3239 0407

OR

Crown Law
GPO Box 149
BRISBANE QLD 4001

STEP 3

After forwarding Part 1 of the Notice to the person/s, **start completing Part 2 of the Notice**. Again, **please use a black or blue pen** and print clearly or type your answers. Work your way through Part 2 of the form carefully, following the "got to" instructions. Attach a separate page with further information if there is not enough space on the form.

You must forward Part 2 of the Notice to the person/s you forwarded Part 1 to within two (2) months of the person's first reply to your Part 1. If they do not reply within 1 month, then you must forward Part 2 of the Notice to them within two months of that date (that is, within three months of the day you first gave them Part 1 of the Notice).

WHAT WILL HAPPEN AFTER YOU SEND YOUR NOTICE OF CLAIM TO THE RESPONDENT

- The **respondent** is the person or persons who you believe is responsible for the incident and who will receive this completed form.

- **You will get a letter from the respondent** telling you that your claim has been received. It will include the name and telephone number of a contact person.

- **You must be prepared to help the respondent with their investigation** of the incident. You may be required to give specific information, photographs, documents or records, and you may have to have a medical examination or assessment. You must also take all reasonable steps to reduce your lost income – for example seeking alternative work.

- **The obligation of the respondent** in relation to your claims is to:

  - Within one (1) month after receiving Part1 of your notice of claim, advise you if there are any areas in the form where the information is deficient;

  - Within six (6) months of receiving a complying Part 1 notice of claim, advise you whether liability is admitted or denied and if admitted to what percentage;

  - If liability is admitted, advise you the respondent is prepared to accept your offer of settlement if you have made one or invite you to make an offer as soon as possible.