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 questions etc. should not be altered in any way**

**Version 5**

## 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:

1. 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;
2. 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
3. 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**)

#### CLAIMANT’S PERSONAL DETAILS

Surname/Family Name:

Given Names:

Title: □ Mr □ Ms □ Mrs □ Miss □ Other

Date of Birth:

Gender: □ Male □ Female*(insert day/month/year)*

Home Address:

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

 Postcode:

Home Telephone Number: ( )

#### DECEASED PERSON’S PERSONAL DETAILS

Surname/Family Name:

Given Names:

Title: □ Mr □ Ms □ Mrs □ Miss □ Other

Date of Birth:

Gender: □ Male □ Female*(insert day/month/year)*

Home Address:

 Postcode:

#### 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)*
1. **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)**

1. **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: Given 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:

Contact 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”.)**

#### 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: ( )

#### DOES THE CLAIMANT NEED AN INTERPRETER?

□ No □ Yes

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

#### 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)

#### 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**

#### 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)

#### GIVE A BRIEF DESCRIPTION OF THE INCIDENT

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

List all injuries:

#### 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)**

#### 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)*

#### 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)*

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

Surname/Family Name: Given Name: Home Address:

 Postcode: Contact Telephone Number: ( )

#### 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.)**

#### 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

#### 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**

1. **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

1. If yes, provide the date, time and place of each consultation with the health care provider in which a warning should have been given:
2. 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?
1. What were the risks about which it is alleged the deceased should have been informed or adequately informed by the health care provider?

#### 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)*

#### 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

1. Give the date the complaint was made to the Commission:
2. 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:

1. **DESCRIBE THE MEDICAL CONDITION FOR WHICH THE DECEASED PERSON SOUGHT TREATMENT:**
2. **DESCRIBE WHAT ASPECT OF THE TREATMENT IS BEING COMPLAINED OF AS CAUSING THE DEATH:**
3. **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.**

#### 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):

#### WHAT WAS THE DECEASED PERSON’S PART IN THE INCIDENT? (DESCRIBE WHAT THE DECEASED PERSON WAS DOING)

1. **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?

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

□ No □ Yes

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

1. **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.)**

#### DID THE DECEASED PERSON GO TO HOSPITAL?

* + No *(if no, tick and go to Q34)*
	+ Yes Hospital: Address:

Date: (insert day/month/year)

#### WAS THE DECEASED PERSON ADMITTED TO HOSPITAL?

* + No
	+ Yes Hospital:

Address:

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

1. **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 of 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 witness.

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 150 penalty units 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 Declaration and Authorisation**

In accordance with section 9(2)(b) of the *Personal Injuries Proceedings Act 2002,* I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within this Part 1 Notice of claim and to obtain information and documents relevant to the claim as specified under the *Personal Injuries Proceedings Regulation 2014*.

I do solemnly and sincerely declare that the statements of fact contained in this Part 1 Notice of Claim (Non-Health Care Claim) (including the attached pages) are true and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867.*

The contents of this statutory declaration are true, except where they are stated on the basis of information and belief, in which case they are true to the best of my knowledge. I understand that a person who makes a declaration that the person knows is false in a material particular commits an offence.

**I state that:**

* This declaration was made in the form of an electronic document.[[1]](#footnote-1)
* This declaration was electronically signed.[[2]](#footnote-2)
* This declaration was made, signed and witnessed under part 6A of the *Oaths Act 1867*.[[3]](#footnote-3)

|  |  |
| --- | --- |
| **DECLARED by** ……………………………………………[full name of signatory]  | .……………………………………. [signature of signatory] |
| at…………………………………………[insert place where signatory is located]  | .……………………………………. [date] |

|  |  |
| --- | --- |
| *(If applicable)***Signed for and at the direction of the** **declarant by**……………………………………………[full name of substitute signatory]………………………………………………….….[Australian legal practitioner/government legal officer/employee of the public trustee, as applicable][[4]](#footnote-4) | ….……………………………………. [signature of substitute signatory] |
| Declared on …………….…….day………..……………month……………..……year  |
|  |  |
| **In the presence of** ……………………………………………[full name of witness] | .…………………………………. [signature of witness] |
| ……………………………………………[type of witness] | .……………………………………. [date] |
| ……………………………………………[witness’s place of employment /employment address / home address / telephone number / email address / law practice, as applicable][[5]](#footnote-5) |  |
| **For special witnesses to complete – Tick as applicable:**☐ I am a special witness under the *Oaths Act 1867**(see section 12 of the Oaths Act 1867)*☐ This document was made in the form of an electronic document [[6]](#footnote-6) ☐ I electronically signed this document [[7]](#footnote-7) ☐ This statutory declaration was made, signed and witnessed under part 6A of the *Oaths Act 1867* – I understand the requirements for witnessing a document by audio visual link and have complied with those requirements [[8]](#footnote-8)***The footnotes are to assist in the completion of the form and can be deleted once complete.*** |

**IF ANOTHER PERSON SIGNED ON BEHALF OF THE INJURED PERSON PURSUANT TO SECTION 9(4) OR SECTION 44(3) OF THE *PERSONAL INJURIES PROCEEDINGS ACT 2002*:**

Full name of Injured Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give Details of the Person who Signed the Form:

Person’s Full Name: Address:

Home Telephone Number: ( )

Relationship to the Injured Person: Reason/s why the Injured Person 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***

#### 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

#### 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)*

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

□ No □ Yes

Give Details:

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

1. **CLAIMANTS’S CLAIMS HISTORY**
2. Have you ever made a claim for damages for a personal injury?

□ No □ Yes

1. 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:

1. **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”.)**

#### 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:

#### 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): \_

#### 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 :

1. social security benefit (give your social security reference number):

Amount: $

1. workers’ compensation (give the insurer’s details and claim number):

Name: Address:

 Postcode: Telephone Number: ( )

Claim Number: Amount:$

1. borrowed money (give the lender’s details):

Name: Address:

 Postcode: Telephone Number: ( )

Amount: $

1. 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).***

#### DECEASED PERSON’S EDUCATIONAL DETAILS

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

(i)

(ii)

(iii)

(iv)

#### 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:

#### 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.)**

#### 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)*

#### 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: ( )

#### 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 NOT SELF-EMPLOYED IMMEDIATELY PRIOR TO THE INCIDENT, GO TO QUESTION 53.**

1. **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 must 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.)**

#### IS THE BUSINESS STILL OPERATING?

□ No □ Yes

#### 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.)**

1. **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)*

#### 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)*

#### 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”)**

1. **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.)**

#### 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.)

1. **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:

1. received a benefit provide their social security number:
2. received workers’ compensation, provide the insurer’s details and claim number:

Name: Address:

 Postcode: Telephone Number: ( )

Claim Number:

1. borrowed money, provide the lender’s details:

Name: Address:

 Postcode: Telephone Number: ( )

1. 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.)**

#### 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 must be 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 of 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 Claimant must declare the content as true before a witness.

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 150 penalty units 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 Declaration and Authorisation**

In accordance with section 9(2)(b) of the *Personal Injuries Proceedings Act 2002,* I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within this Part 1 Notice of claim and to obtain information and documents relevant to the claim as specified under the *Personal Injuries Proceedings Regulation 2014*.

I do solemnly and sincerely declare that the statements of fact contained in this Part 1 Notice of Claim (Non-Health Care Claim) (including the attached pages) are true and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867.*

The contents of this statutory declaration are true, except where they are stated on the basis of information and belief, in which case they are true to the best of my knowledge. I understand that a person who makes a declaration that the person knows is false in a material particular commits an offence.

**I state that:**

* This declaration was made in the form of an electronic document.[[9]](#footnote-9)
* This declaration was electronically signed.[[10]](#footnote-10)
* This declaration was made, signed and witnessed under part 6A of the *Oaths Act 1867*.[[11]](#footnote-11)

|  |  |
| --- | --- |
| **DECLARED by** ……………………………………………[full name of signatory]  | .……………………………………. [signature of signatory] |
| at…………………………………………[insert place where signatory is located]  | .……………………………………. [date] |

|  |  |
| --- | --- |
| *(If applicable)***Signed for and at the direction of the** **declarant by**……………………………………………[full name of substitute signatory]………………………………………………….….[Australian legal practitioner/government legal officer/employee of the public trustee, as applicable][[12]](#footnote-12) | ….……………………………………. [signature of substitute signatory] |
| Declared on …………….…….day………..……………month……………..……year  |
|  |  |
| **In the presence of** ……………………………………………[full name of witness] | .…………………………………. [signature of witness] |
| ……………………………………………[type of witness] | .……………………………………. [date] |
| ……………………………………………[witness’s place of employment /employment address / home address / telephone number / email address / law practice, as applicable][[13]](#footnote-13) |  |
| **For special witnesses to complete – Tick as applicable:**☐ I am a special witness under the *Oaths Act 1867**(see section 12 of the Oaths Act 1867)*☐ This document was made in the form of an electronic document [[14]](#footnote-14) ☐ I electronically signed this document [[15]](#footnote-15) ☐ This statutory declaration was made, signed and witnessed under part 6A of the *Oaths Act 1867* – I understand the requirements for witnessing a document by audio visual link and have complied with those requirements [[16]](#footnote-16)***The footnotes are to assist in the completion of the form and can be deleted once complete.*** |

**IF ANOTHER PERSON SIGNED ON BEHALF OF THE INJURED PERSON PURSUANT TO SECTION 9(4) OR SECTION 44(3) OF THE *PERSONAL INJURIES PROCEEDINGS ACT 2002*:**

Full name of Injured Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give Details of the Person who Signed the Form:

Person’s Full Name: Address:

Home Telephone Number: ( )

Relationship to the Injured Person: Reason/s why the Injured Person 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 witness.

***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 the 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 caused** the incident, then the Notice of Claim must nominate the Government Department which you believe caused the incident and be delivered to:

|  |  |  |
| --- | --- | --- |
| Crown Law |  | Crown Law |
| Level 11 |  | GPO Box 149 |
| State Law Building | OR | BRISBANE QLD 4001 |
| 50 Ann Street |  |  |
| BRISBANE QLD 4000Facsimile: (07) 3239 0407 |  |  |

#### 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.
1. *[The footnotes are to assist in the completion of the form and can be deleted once complete.]*

 Tick this box if you electronically signed the document or if you physically signed the document over audio visual link and then sent a scanned copy of that document to the witness. [↑](#footnote-ref-1)
2. Tick this box if you or your substitute signatory electronically signed the document using an accepted method under the *Oaths Act 1867.* Do not tick this box if you signed the document on paper. [↑](#footnote-ref-2)
3. Tick this box if the document was made over audio visual link. [↑](#footnote-ref-3)
4. *[The footnotes are to assist in the completion of the form and can be deleted once complete.]*

 A person may be directed by AV link to sign a document for a signatory only if the person is: an Australian legal practitioner; or a government legal officer under the *Legal Profession Act 2007* (who is an Australian lawyer but not an Australian legal practitioner and witnesses documents in the course of the government work engaged in by the officer); or is an employee of the public trustee (s 31P, *Oaths Act 1867*). [↑](#footnote-ref-4)
5. Legal practitioners who witness this document as a special witness must include their law practice (s 13E *Oaths Act 1867*). [↑](#footnote-ref-5)
6. Tick this box if you electronically signed the document or if you physically signed the document and sent a scanned copy of that document to the signatory. [↑](#footnote-ref-6)
7. Tick this box if you electronically signed the document using an accepted method under the *Oaths Act 1867*. Do not tick this box if you signed the document on paper. [↑](#footnote-ref-7)
8. Tick this box if the document was made over audio visual link. [↑](#footnote-ref-8)
9. *[The footnotes are to assist in the completion of the form and can be deleted once complete.]*

 Tick this box if you electronically signed the document or if you physically signed the document over audio visual link and then sent a scanned copy of that document to the witness. [↑](#footnote-ref-9)
10. Tick this box if you or your substitute signatory electronically signed the document using an accepted method under the *Oaths Act 1867.* Do not tick this box if you signed the document on paper. [↑](#footnote-ref-10)
11. Tick this box if the document was made over audio visual link. [↑](#footnote-ref-11)
12. *[The footnotes are to assist in the completion of the form and can be deleted once complete.]*

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13. Legal practitioners who witness this document as a special witness must include their law practice (s 13E *Oaths Act 1867*). [↑](#footnote-ref-13)
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16. Tick this box if the document was made over audio visual link. [↑](#footnote-ref-16)