## Workers Compensation Journey claim form



**INSURANCE SERVICES** 

Employer name			
Claim number			
Please print in block letters.			
1. About the worker			
Full name	Date of b	oirth	
	/	/	
Address			
Employer name			
1. About the journey			
Date and time of accident? Date / / Time am/pm			
What mode of transport were you using? (eg motor vehicle, public transport, walking, other)			
Where exactly did the accident occur? Street/Road			
Suburb/Town			
Where were you travelling to? (eg work, home, technical school) Following your usual route?	Yes	No	, 🗆
	_	_	
Where were you travelling from? (eg work, home, technical school) Following your usual route?	Yes	No	
Did you divert from your usual route?  Was their any interruption to the journey?	Yes L	→ No → No	
f yes, please provide details	103	_ 110	
<u> </u>			
Had you consumed any alcohol or drugs in the 12 hours immediately prior to the accident?	Yes	No	
If yes, how much?	163	_ 140	

Vehicle owner's name (if different from driver)  Vehicle owner's address (if different from driver)  Suburb  State  Postcode	3. What happened?									
Address  In your opinion, who was responsible for the accident. And why?  4. Traffic accident details  About the vehicle in which you were injured  Registration number  Driver's name  License number  Expiry date  / / /  Residential address  Phone  (i)  Vehicle owner's name (if different from driver)  State of registration  Vehicle owner's address (if different from driver)  Suburb  State  Postcode  Phone  (i)  State  Postcode  Phone  (ii)  State  Postcode  Phone  (iii)  State  Postcode	How did the accident of	occur?								
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				]		•				
Driver's name	Registration number			State of registrat	ion					
	Driver's name									

Owner's name  Residential address  Suburb State Postcode  Phone  ( )  6. About the accident  Police station to which the accident was reported	Residential address					
Phone  ( )  Owner's name  Residential address  Suburb State Postcode  Phone  ( )  6. About the accident  Police station to which the accident was reported						
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Police station to which the accident was reported	( )					
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Other vehicles  Pedestrian, Cyclist, etc.				indicate by		
Pedestrian, Cyclist, etc.	Your vehicle	<b>—</b>				
	Other vehicles	<b>□→</b>				
Intersection	Pedestrian, Cyclist, etc.	$\longrightarrow$				
	Intersection					

## How to return this form

> Email: insurance@provident.com.au

> Fax: (08) 9389 5852

Post: Provident Insurance ServicesPO BOX 424 Nedlands, WA 6909

## How to contact us

> Phone: (08) 9442 0000

> Web: www.provident.com.au