



Self Employed Economic Loss

1. Claimant's Name

2. Date of Birth

3. Date of Crash

4. Provide the following details

Type of business

Business name and address

Australian Business Number (ABN)

5. Estimate the loss suffered by the business as a result of the crash

Provide a brief statement detailing what loss of earning capacity you have sustained and how you calculated that loss. If you require more space, use a blank sheet of paper and label your answer "Estimated Loss".

6. What is your Net weekly wage figure?

7. Has the business ceased trading since the crash?

No

Yes

Please explain why the business ceased

8. Have you lodged any taxation returns for the 3 financial years before the crash?

No

Attach an income and expenditure statement (including any business activity statements) prepared in accordance with the Income Tax Assessment Act 1936, for the previous financial year, or from commencement of the business to the time of the crash.

Yes

Attach copies (include **all** attachments and business activity statements lodged with the Taxation Office).

9. Have you employed substitute labour?

No

Yes

Provide details of who you have employed.

Provide a separate **supporting statement** detailing:

- Name(s) of person(s)
- Contact details of each person
- Nature of duties performed
- Period of each employment
- Gross and net wages paid each week
- Method of taxation deductions made (e.g Group withholding tax)
- Documentary evidence of payment such as cheque butts, bank statements etc.

10. Have you derived any other income (excluding rent or interest)?

Provide details

11. Have you claimed Workers Compensation as a result of this crash?

No Yes

Provide details of the insurer

Claim number

12. Have you had any *previous* Workers Compensation claims?

No Yes

Provide details of the date, employer, insurer and claim number(s)

13. Have you claimed on any *other personal insurance policy for loss of income*?

No Yes

Provide details of the date, employer, insurer and claim number(s)

14. Provide *details of your accountant or the person to contact regarding your personal income records*

Name

Address

Telephone number

15. Have you received any *Centrelink* Benefits?

No Yes

Provide details of the benefit and reference number

Information Confidentiality

Please note that Section on 42 of the *Insurance Commission of Western Australia Act 1986* prevents the Insurance Commission of Western Australia from divulging information, except in the performance of a function or duty under or in connection with any written law or as required by any other legal duty.

I declare that the information provided in this document is true and correct to the best of my knowledge. It is an offence to provide false or misleading information in this document. Section 27B *Motor Vehicle (Third Party Insurance) Act 1943* – penalty \$10,000.

The Insurance Commission of Western Australia collects personal information through this form as authorised by law to assess motor injury insurance claims. If you are making such a claim, please note that to enable us to manage your claim, we will continue to collect other personal information from you and other relevant parties such as the WA Police Force, Department of Health, Department of Transport and Major Infrastructure, St John Ambulance, health service providers and solicitors. Personal information in this form is shared with other authorised parties where necessary and authorised by law. For further details on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

Claimant

Signature of Claimant

Address

Date

Contact Number

Authority to Release Information

I, _____ of _____ authorise my accountant(s) or those that manage my financial records to release to the Insurance Commission of Western Australia or its representative(s) any and all information in respect of my business(es) and employment. Furthermore, I authorise any insurer from whom I have claimed or held a policy with, for personal injury, to release to the Insurance Commission of Western Australia, all details in respect of such claim or policy.

Signed _____

Date _____

IF YOU ARE UNABLE TO INSERT A DIGITAL SIGNATURE TYPE NAME HERE

Claim Number: