Insurance Commission of Western Australia

Claim No:

REQUEST FOR ADVANCE PAYMENT BY

TO

INSURANCE COMMISSION OF WESTERN AUSTRALIA

Please complete all questions 1 - 4

1. I of request an advance payment against my claim for compensation for past loss of earning capacity as a result of the motor vehicle crash on .

2. I understand I am required to complete this form before my request for an advance payment is considered by the Insurance Commission of Western Australia (ICWA).

3. At the date of the crash I was **employed** ☐ or **self-employed** ☐ (tick as applicable).

4. I confirm Doctor _____ has certified that I am medically **totally** ☐ or **partially** ☐ (tick as applicable) unfit to return to employment (paid or unpaid).

Please complete questions 5 - 7 if you have not resumed employment in any capacity

5. I confirm that since the crash I have not resumed my employment or any other form of employment paid or unpaid. ☐

6. My average net income after tax at the date of the crash was $_____ per week.

7. I request an advance payment for period ____ /____ /____ to ____ /____ /____ (number of weeks: _____) in the sum of $_____.

OR

Please complete questions 8 - 11 if you have resumed employment in a partial capacity

8. I confirm that since the crash I have partially resumed employment ☐

9. I resumed employment on ____ /____ /____ .

10. My current net weekly income after tax is $_____.

11. I request an advance payment of $_____ being the difference between my pre and post-crash weekly income for the period ____ /____ /____ to ____/___/___ (number of weeks: _____) in the sum of $_____.

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Please complete all questions 12 - 14

12. I **have**☐/**have not**☐ (tick as applicable) received Centrelink Benefits since the crash.

13. I **have**☐/**have not**☐ (tick as applicable) received income from another insurance policy.

    If you have received income from another insurance policy, please provide:

    a. Name of insurer _____.
    b. Policy number _____.
    c. Claim number _____.
    d. Net income per week $_____.
    e. For the period _____ /_____ /_____ to _____ /_____ /_____ .

14. I declare that the information I have provided is true and correct. I acknowledge that should I sign this statement knowing any information presented is false or misleading I am committing a criminal offence under Section 27B of the *Motor Vehicle (Third Party Insurance) Act 1943* and may be liable to a penalty of $10,000.00

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.

Signed (claimant): _____ Dated: _____

Original signature only – copies of signature will not be accepted

_____

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

Download the form on your computer, and once complete, send to ctp@icwa.wa.gov.au

PRINT CLEAR