|  |  |  |  |
| --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | Information about claiming Use this form to claim reimbursement for general expenses.  This declaration should not be used for claiming expenses for:   * Travel to medical appointments * Pharmacy expenses * Home or domestic services * Family accommodation and/or travel expenses.   If you do use this form to claim the above expenses, the form and receipts will be returned to you to complete and submit the correct form.  Please attach your original receipts to this form. If you do not attach original receipts they will be returned to you unpaid.  The TAC recommends keeping copies of any receipts that you send to the TAC. |  | Your privacy  The TAC respects your privacy. The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information.  Without this information, the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment.  If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at www.tac.vic.gov.au  Are your bank details up to date?  If you have recently changed your bank details, please update your bank details with us to prevent unnecessary delays in your reimbursement.  The *Electronic Funds Transfer (EFT) Authority form for TAC clients* is available on our website. | |

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| --- |
| **It is important that you read the information below** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client details** |  |  | | |
| Name |  | Claim number | | |
|  |  |  | | |
| Address |  | Date of birth |  | Date of accident |
|  |  | /     / |  | /     / |
| Post code |  |  | | |

|  |  |  |
| --- | --- | --- |
| **Name of person claiming expenses** (leave blank if TAC client)  Name |  | **Bank account details**  Name of account |
|  |  |  |
| Contact phone number |  | Name of bank |
|  |  |  |
| Address |  | Bank address |
|  |  |  |
| Post code |  | BSB of (for international – Branch Code/Sort Code/CHIPS) |
| Relationship to client |  |  |
|  |  | Account number |
|  |  |  |

# Declaration

I confirm that all these services are for my transport accident injuries and not for any pre-accident or unrelated condition.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of client, parent or guardian |  | Print name |  | Date |
|  |  |  |  | /     / |
|  |  |  |  |  |

**Under section 117 of the *Transport Accident Act 1986* it is an offence to provide false or misleading information in connection with a claim.**

# I have attached original receipts for:

Equipment, such as crutches, wheelchair, etc.

Treatment, such as physiotherapy, chiropractor, etc.

Other, please specify

|  |
| --- |
|  |