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Website: www.maib.tas.gov.au

CLAIM NUMBER _ _ _ _ _ _ _ _ _ _

Application for Scheduled Benefits

For Dependants of Deceased

FORM E

- **To be completed by a representative for, or on behalf of, the dependants of the deceased.**
- **Attach with evidence which identifies in what manner and extent to which each person named was financially dependent on the deceased at the time of the motor accident.**

Accident Details

Full Name of Deceased	Surname
	Given Names

Date of Birth   /   /   Date of the Accident   /   /

Home Address	
	City
	State P/code

Employment Details

Was the deceased: Employed ☐ Self Employed ☐ A Student ☐ Pensioner ☐ Other ☐

If **employed**

Occupation(s)	Name and Address of Employer(s)

If **self employed**

Occupation(s)	Name and Address of Registered Business/Businesses

If **other**, please specify

Details of the Deceased's Dependants

1.

Full Name of Dependant			
Home Address			
	City State P/code		
Date of Birth			
Is this person a full time student?		Relationship to the deceased	
Nature of Dependency *(the manner and extent to which the dependant was dependent on the deceased for financial support)*			$ per week

Details of the Deceased's Dependants

2.

Full Name of Dependant			
Home Address			
	City	State	P/code
Date of Birth			
Is this person a full time student?		Relationship to the deceased	
Nature of Dependency *(the manner and extent to which the dependant was dependent on the deceased for financial support)*			$ per week

3.

Full Name of Dependant			
Home Address			
	City	State	P/code
Date of Birth			
Is this person a full time student?		Relationship to the deceased	
Nature of Dependency *(the manner and extent to which the dependant was dependent on the deceased for financial support)*			$ per week

Please copy form for any additional dependants.

Declaration

Particulars of person completing this form on behalf of the deceased's dependants

Surname		
Given Names		
Home Address		
	State	Postcode
Contact Details	Work Phone: ( )	Home Phone: ( )
	Mobile Phone:	Fax: ( )
	Email:	

Your relationship to the deceased
(e.g. sister, spouse, representative of the Estate, etc.)

I declare that the information provided in this form is, to the best of my knowledge and belief, a true and correct record.

Signature of Representative Dated

General Authority

I hereby consent to the Motor Accidents Insurance Board or its servants or agents disclosing or using, whether generally or under any Personal Information Act, Personal Information for the purposes of determining its obligations under the Motor Accidents (Liabilities and Compensation) Act 1973 and to investigate the motor accident which occurred on or about the above accident date.

A clear photocopy or imagery reproduction of this authority is to be considered as valid as the original.

Signature of Representative Dated

F & P 35624 MAY13M8