1st Floor,
33 George Street, Launceston
PO Box 590, Launceston 7250
DX 70112, Launceston
Telephone: (03) 6336 4800

TOLL FREE 1800 006 224

Facsimile: (03) 6336 4848
Email: info@maib.tas.gov.au
Website: www.maib.tas.gov.au

CLAIM NUMBER __ __ __ __ __ __ __ __ __ __

Self-Employed Persons Claim for Lost Wages

FORM F

Claimant's Personal Details

Question 1

Surname

Given Names

Date of Birth / /

Date of Accident / /

Your Occupation(s)

Name of Business

Business Address

State Postcode

Postal Address *(if same as above, write "as above")*

State Postcode

Contact Phone Numbers ( ) Business ( ) After Hours

Claim Details

Question 2

Business Status
(e.g. Sole Trader, Partnership, Family Trust, etc.)

Name of Accountant where records are maintained

Accountant's Business Address

State Postcode

Claim Details

Question 3

Has the business ceased completely since the accident? ☐ NO ☐ YES

Question 4

What date were you first absent from your business as a result of the motor vehicle accident injuries?

Question 5

Have you employed substitute labour because of your injuries? ☐ NO ☐ YES

If YES, provide details below

Name of Substitute

Address

State Postcode

Question 6

Have you recommenced working? ☐ NO ☐ YES

If Yes, date returned / /

Total Days Absent days

Declaration

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

Full Name

Signature Dated