Australian Government
Services Australia

# COVID-19 Vaccine Claims Scheme – Application (MO062)

## When to use this form

Use this form to apply for compensation under the COVID-19 Vaccine Claims Scheme (the Scheme). The Scheme gives people a way to seek compensation instead of going through legal proceedings.

You (the claimant) can submit a claim for yourself or someone you are authorised to represent as long as you meet the eligibility requirements under the Scheme.

## Who can get it

You need to meet the following requirements to be eligible for a one-off payment under the Scheme.

The patient must have:

- received a Therapeutic Goods Administration (TGA) approved COVID-19 vaccine
- met the definition of harm, like one of the clinical conditions listed in the policy
- been admitted to hospital as an inpatient or claimed a waiver if seen in an outpatient care setting
- losses or expenses of $1,000 or more, not including pain and suffering, due to the COVID-19 vaccination.

Only one claim can be made for each harm. You may wish to:

- consider waiting until you know the full impact of the Harm and associated costs
- talk to your doctor about whether you are eligible.

## Completing this form online is faster and easier

- **Online** – If the patient is yourself or a child younger than 14 that is on your Medicare card, you can claim using your Medicare online account through myGov.

  For help, go to **servicesaustralia.gov.au/onlineguides**

  If you do not have a myGov account, you can create one at **my.gov.au** and then link Medicare to it.
- Use this form – if you cannot claim online or are not eligible for Medicare.

## Supporting documents to process your claim

This form includes a checklist to help you make sure that all information and supporting documents have been included with this application. If you do not do this, it will take us longer to check if you are eligible.

Your doctor needs to complete a **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form so you can submit it with your claim.

## For more information

To find out more information about the:

- **COVID-19 vaccine claims scheme**, go to **servicesaustralia.gov.au/covid19vaccineclaims** or call **1800 653 809** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.
  Call charges may apply.
- **COVID-19 Vaccine Claims Scheme Policy 2021**, go to **health.gov.au** for a copy of the policy.

## Information in your language

For Medicare, call **132 011** (call charges may apply). Let us know if you need an interpreter and we will arrange one for free.

Go to **servicesaustralia.gov.au/yourlanguage** to read, listen to or watch information in your language.

## Hearing and speech assistance

If you have a hearing or speech impairment, you can use:

- the National Relay Service **1800 555 660**, or
- our TTY service on **1800 810 586**. You need a TTY phone to use this service.

For more information about help with communication, go to **servicesaustralia.gov.au** and search 'other support and advice'.

## Returning this form

Return this form and any supporting documents by:

- **email** to **COVID19.vaccine.claims.scheme@servicesaustralia.gov.au**
  There may be risks with sending personal information through unsecured networks or email channels.
- post to
  Services Australia
  COVID-19 Vaccine Claims Scheme
  PO Box 1001
  TUGGERANONG ACT 2901

## Filling in this form

You can fill this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and complete it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

## Patient's details (person who received the vaccine)

**1** Medicare card number (if known)

Ref no.

**or**

Individual Healthcare Identifier

8 0 0 3 6 0

**2** Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

**3** Date of birth (DD MM YYYY)

**4** Postal address

Postcode

**5** Daytime phone number (including area code)

Mobile phone number

Email

## Claimant's details

**6** Is the patient also the claimant?

No ☐

Yes ☐ ***Go to 17***

Provide proof of identity documents for the patient.

**7** Are you (the claimant) authorised to represent the patient?

No ☐

STOP You are not eligible to claim for this patient. For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

Yes ☐

You will need to complete and return an **COVID-19 Vaccine Claims Scheme – Authorising a person or organisation to act on your behalf (MO064)** form.

If you do not have this form, go to **servicesaustralia.gov.au/forms**

**8** Is the claimant an individual or entity?

**Tick one only**

Individual ☐ ***Go to 11***

Entity ☐

**9** Business name

**10** Australian Business Number (ABN)

***Go to 12***

**11** Medicare card number (if known)

Ref no.

**or**

Individual Healthcare Identifier

8 0 0 3 6 0

**12** Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

**13** Date of birth (DD MM YYYY)

**14** Postal address

Postcode

MCA0MO062 2309

**15** Daytime phone number (including area code)

Mobile phone number

Email

**16** In what capacity are you completing the form on behalf of the patient?

**Tick all that apply**

Carer ☐
Family member ☐
Power of attorney ☐
Other ☐ Give details below

## Details of COVID-19 vaccine that caused the Harm

**17** Date the vaccine was given (DD MM YYYY)

**18** What was the name of the vaccine?

**Tick one only**

AstraZeneca Vaxzevria ☐
Moderna Spikevax ☐
Novavax Nuvaxovid ☐
Pfizer Comirnaty ☐
Other ☐ Give details below

**19** Where was the vaccine given?

Postcode

## Details of Harm suffered by the patient

**20** Did the patient suffer Harm that is most likely caused by the COVID-19 vaccine?

No ☐ STOP This claim is not eligible under the COVID-19 Vaccine Claims Scheme. For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

Yes ☐

**21** Which best describes the adverse reaction?

**Tick one only**

Developed a clinical condition ☐ ***Go to 22***
Administrative related Harm ☐ ***Go to 23***

**22** Has the patient been diagnosed with a clinical condition developed by the COVID-19 Vaccine:

- that is diagnosed by a Treating Practitioner, and
- is included in the Product Information in relation to the COVID-19 Vaccine received by the COVID-19 Vaccine Recipient?

No ☐ ***Go to 23***
Yes ☐ Give details of the clinical condition(s)

**Tick all that apply**

Eligible Clinical Condition / Applicable COVID-19 Vaccine(s) / Diagnosed by:

Anaphylactic Reaction ☐
Astra Zeneca/Pfizer/Moderna/Novavax
All medical practitioners

Thrombosis with Thrombocytopenia Syndrome ☐
AstraZeneca
Haematologist

Myocarditis ☐
Pfizer/Novavax/Moderna
Cardiologist

Pericarditis ☐
Pfizer/Novavax/Moderna
Cardiologist

Capillary Leak Syndrome ☐
AstraZeneca
Intensive Care Medicine or Haematologist

Guillain Barre Syndrome ☐
AstraZeneca
Neurologist or Immunologist

Thrombocytopenia / Immune Thrombocytopenia ☐
AstraZeneca
Haematologist or Immunologist

Transverse Myelitus ☐
AstraZeneca
Neurologist or Immunologist

Cerebral Venous Sinus Thrombosis (CVST) without Thrombocytopenia ☐
AstraZeneca
Haematologist or Neurologist

Erythema Multiforme (Major) ☐
Pfizer/Moderna
Dermatologist or Immunologist

Provide a **COVID-19 Vaccine Claims Scheme – Medical report (M0063)** form completed by the treating practitioner or a reporting practitioner who has all the patient's relevant medical reports to complete the form.

***Go to 24***

**23** Has the patient been diagnosed with an injury:

- sustained during the physical act of administering a COVID-19 vaccination, or
- other moderate to significant physical injury giving rise to permanent impairment or the need for extended medical treatment?

No ☐

Yes ☐ List the injury diagnosed

Provide a **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form completed by the treating practitioner or a reporting practitioner who has all the patient's relevant medical reports to complete the form.

**24** Provide a statement outlining the circumstances that led to this claim. Provide dates the patient saw health professionals, etc.

If you need more space, provide a separate sheet with details.

**25** Was the patient admitted to hospital as an inpatient as a result of being given the vaccine?

No ☐

Yes ☐ Provide evidence of inpatient hospitalisation – needs to show what you were treated for and date of admission and discharge.

***Go to 27***

**26** Why was the patient not admitted to hospital as an inpatient?

☐ Due to the nature of the Harm suffered

☐ The patient was in a rural or remote area at the time the Harm was suffered, making it difficult for them to access a Hospital.

Provide evidence to support the location of where the patient was when they suffered the Harm.

☐ Patient died

Date of death (DD MM YYYY)

Provide death certificate.

***Go to 44***

☐ None of the above

STOP This claim is not eligible under the COVID-19 Vaccine Claims Scheme.
For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

**27** Was the patient under the care of a medical practitioner that was qualified in a specialty or a field of speciality practices relevant to the Harm suffered?

No ☐ STOP This claim is not eligible under the COVID-19 Vaccine Claims Scheme.
For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

Yes ☐ The reporting practitioner will need to provide more details when completing the **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form

***Go to 31***

**28** Hospital name

**29** Hospital address

Postcode

**30** Date of admission

From (DD MM YYYY)

To (DD MM YYYY)

## Compensation

**31** Has the patient claimed, or is there any intention to claim any other compensation in relation to the Harm being claimed in this application through any other means, for example workers compensation?

No ☐

Yes ☐ Give details below

## Costs being claimed

**32 Read this before completing the tables at questions 33 to 40.**

To be eligible, your claim must include (past and/or future) costs for at least one of the following:

- lost earnings
- out of pocket expenses
- paid attendant care services
- gratuitous attendant care
- loss of capacity to provide domestic services

that equal or exceed $1,000.

You need to provide evidence of this. If no third party payer exists, please provide a signed detailed statement to this effect. We also need a signed detailed statement confirming whether you have or are entitled to receive payment(s) from any other third party payer for any of the claim categories listed above.

If you do not want to write your own statement, you can complete the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form instead. Completing the MO066 may make processing of your claim faster.

The amounts being claimed should not include any amounts that are claimable for another third party, for example if you had a medical bill for $100 and a private health fund subsidises $40 the amount that can be claimed is $60. This is regardless of if you have or have not claimed a subsidy. This also applies if you received the same income you normally would have from third parties such as sick leave from your employer.

For a breakdown of what costs are claimable and the evidence required, go to **servicesaustralia.gov.au/covid19vaccineclaims**

If you need more space for any of the costs being claimed, provide a separate sheet with details.

### Lost earnings

**33 Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **past lost earnings**?

No ☐ ***Go to 34***

Yes ☐ Give details below

Amount claimed (Column E) should be past lost earnings per week (Column A) minus Amount paid by third party (Column B) multiplied by Number of weeks (Column D).

For example, if your weekly earnings was $1,000 but instead you were paid $400 under income protection or a Centrelink payment, you should enter $1,000 in Column A, $400 in column B, and $600 in the amount claimed.

| A | B | C | | D | E |
|---|---|---|---|---|---|
| **Past lost earnings** per week | Amount paid or payable by third party, for example social welfare payments or employer sick leave per week | Date range covered* From (DD MM YYYY) | Date range covered* To (DD MM YYYY) | Number of weeks | Amount claimed (Column A minus Column B) x Column D = Column E |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| | | | Total amount claimed for **past lost earnings** | | $ |

Provide supporting documentation. For example, payslips.
You **must** provide evidence showing your earnings for the **month before** you were injured to the end of the date range covered. If your earnings are not a standard amount we will need evidence for the **3 month period before** you were injured to the end of the date range covered.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

* This date must align with the date your reporting practitioner entered in the **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form.

**34** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **future lost earnings**?

No ☐ ***Go to 35***

Yes ☐ Give details below

| A | B | C | | | D | E |
|---|---|---|---|---|---|---|
| **Future lost earnings** per week | Amount paid or payable by third party, for example social welfare payments or employer sick leave per week | Date range covered* | | | Number of weeks | Amount claimed (Column A minus Column B) x Column D = Column E |
| | | From (DD MM YYYY) | | | | |
| | | To (DD MM YYYY) | | | | |
| $ | $ | | | | | $ |
| $ | $ | | | | | $ |
| $ | $ | | | | | $ |
| $ | $ | | | | | $ |
| $ | $ | | | | | $ |
| $ | $ | | | | | $ |
| | | | | Total amount claimed for **future lost earnings** | | $ |

Provide supporting documentation. For example, a letter from your employer outlining future employment arrangements.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

* This date must align with the date your reporting practitioner entered in the **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form.

## Out of pocket expenses

**35** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **past out of pocket expenses**?

No ☐ ***Go to 36***

Yes ☐ Give details below

| A | B | C | D | E |
|---|---|---|---|---|
| **Past out of pocket expenses** | Amount paid or payable by third party, for example Medicare benefits payable or private health insurance | Invoice number | Date of invoice (DD MM YYYY) | Amount claimed Column A minus Column B = Column E |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| | | | Total amount claimed for **past out of pocket expenses** | $ |

Provide supporting documentation. For example, invoices for each amount claimed.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

**36** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **future out of pocket expenses**?

No ☐ ***Go to 37***

Yes ☐ Give details below

| A | B | C | | D |
|---|---|---|---|---|
| **Future out of pocket expenses** | Amount paid or payable by third party, for example Medicare benefits payable or private health insurance | Date range | | Amount claimed<br>Column A minus Column B = Column D |
| | | From (DD MM YYYY) | To (DD MM YYYY) | |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| | | Total amount claimed for **future out of pocket expenses** | | $ |

Provide supporting documentation. For example, treatment plans or quotes for future treatment of harm.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

## Paid attendant care services

**37** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **past paid attendant care services**?

No ☐ ***Go to 38***

Yes ☐ Give details below

| A | B | C | D | E |
|---|---|---|---|---|
| **Past paid attendant care services** | Amount paid or payable by third party, for example private health insurance | Invoice number | Date of invoice (DD MM YYYY) | Amount claimed<br>Column A minus Column B = Column E |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| $ | $ | | | $ |
| | | Total amount claimed for **past paid attendant care services** | | $ |

Provide supporting documentation. For example, invoices for each amount claimed.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

**38** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

Are you claiming **future paid attendant care services**?

No ☐ ***Go to 39***

Yes ☐ Give details below

| A | B | C | D | E | F |
|---|---|---|---|---|---|
| **Future paid attendant care services** per hour of care | Amount paid or payable by third party, for example private health insurance | Type of care service | Hours per week care required | Number of weeks of future care needed | Amount claimed (Column A minus Column B) x Column D = Column F |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| $ | $ | | | | $ |
| | | | | Total amount claimed for **future paid attendant care services** | $ |

Provide supporting documentation. For example, quotes for each amount claimed.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

## Gratuitous attendant care services

**39** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

To be eligible to claim gratuitous attendant care services you must have been or are to be provided care services for at least 6 hours per week and for a period of at least 6 consecutive months.

The hours and weeks entered in the first column below needs to align with responses provided by the reporting practitioner in the **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form.

Are you claiming **gratuitous attendant care services**?

No ☐ ***Go to 40***

Yes ☐ Give details below

| A | B | C | D | E | F |
|---|---|---|---|---|---|
| **Gratuitous attendant care services** number of hours of care needed per week (cannot exceed 40 hours per week) | Hourly rate | Cost per week Column A x Column B = Column C (Maximum amount is $1,737.10) | Number of weeks provided/required | Amount paid or payable by third party, for example private health insurance | Amount claimed (Column C x Column D) minus Column E = Column F |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | | | | Total amount claimed for **gratuitous attendant care services** | $ |

You will need to provide a separate statement with details to support your claim that includes:

- details of the gratuitous attendant care services
- a summary of the gratuitous care services provided
- the nature and duration of the care services.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

## Loss of capacity to provide domestic services to care recipients

**40** **Read** this before answering the following question.

Your response must be supported by your Medical Practitioner in the **COVID-19 Vaccine Claim Scheme – Medical report (MO063)** form.

To be eligible to claim loss of capacity to provide domestic services you provided the services to the care recipient(s) before the harm was suffered and would have continued to do this service for at least 6 hours per week and for a period of at least 6 consecutive months and the care recipient was not (or will not be) capable of performing the domestic services themselves by reason of their age or physical or mental incapacity.

Are you claiming **loss of capacity to provide domestic services to care recipients**?

No ☐ ***Go to 41***

Yes ☐ Give details below

| A | B | C | D | E | F |
|---|---|---|---|---|---|
| Number of hours of domestic services no longer provided per week but there was/is a need for them to be provided for those hours | Hourly rate | Cost per week Column A x Column B = Column C | Number of weeks provided/required | Amount covered by third party, for example respite care | Amount claimed (Column C x Column D) minus Column E = Column F |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | $ 43.43 | $ | | $ | $ |
| | | | | Total amount claimed for **lost domestic services** | $ |

You will need to provide a separate statement with details to support your claim that includes:

- details of the care recipient(s)
- a summary of the domestic duties performed
- there was a need for these duties to be performed for those periods and times and that the need is reasonable in all the circumstances
- why the care recipient(s) could not perform the duties themselves
- 1 primary document as proof of identity for the care recipient(s). Refer to question 51 for the list of primary documents.

You may find it easier to complete and return the **COVID-19 Vaccine Claims Scheme – Third Party Statement (MO066)** form at the back of this form to support your claim. Completing the MO066 may make processing of your claim faster.

**41** **Total amount claimed** (Refer to totals in tables at question 33–40)

| Total amount claimed for: | Amount claimed |
|---|---|
| • past lost earnings | $ |
| • future lost earnings | $ |
| • past out of pocket expenses | $ |
| • future out of pocket expenses | $ |
| • past paid attendant care services | $ |
| • future paid attendant care services | $ |
| • gratuitous attendant care services | $ |
| • lost capacity for domestic services | $ |
| **Total amount claimed** | $ |

**42** Are there any other amounts paid or payable to you from third parties for the losses you are claiming at questions 31–38?

No ☐

Yes ☐ Give details below

**43** Are you claiming pain and suffering?

No ☐

Yes ☐ Give details of your pre-vaccinated circumstances, ability to lead a normal life and any other information you consider relevant.

Do not enter an amount for pain and suffering. The amount will be determined in line with the policy.

Claims for pain and suffering must be in conjunction with another claim loss component. Please refer to question 32 for eligible claim loss components.

## Tier 3 claim

**44** **Read** this before answering the next question.

**Dependant** means any of the following persons:

- the person to whom the COVID-19 vaccine recipient was legally married, at the time the deceased COVID-19 vaccine recipient died
- a person who was in a de facto relationship (as that term is defined in section 4AA of the *Family Law Act 1975* (Cth)) with the COVID-19 vaccine recipient, at the time the deceased COVID-19 vaccine recipient died
- a child of the COVID-19 vaccine recipient (whether biological or derived from adoption or otherwise) who was wholly, mainly or partly dependent on the earnings of the COVID-19 vaccine recipient at the time the deceased COVID-19 vaccine recipient died
- a child born after the death of the deceased COVID-19 vaccine recipient where the deceased COVID-19 vaccine recipient is that child's parent (whether biological, derived from adoption or otherwise), and
- any other person that was wholly, mainly or partly dependent on the earnings of the COVID-19 vaccine recipient at the time the deceased COVID-19 vaccine recipient died.

Did the patient have any surviving dependant(s) at the time of their death?

No ☐ ***Go to 46***

Yes ☐ Give details below

**Surviving dependant 1**

Full name

Relationship to deceased | Age

Address

Postcode

Contact phone number (including area code)

Was this dependant wholly, mainly or partly dependent on the earnings of the patient when they died?

Wholly ☐ Mainly ☐ Partly ☐

**Surviving dependant 2**

Full name

Relationship to deceased | Age

Address

Postcode

Contact phone number (including area code)

Was this dependant wholly, mainly or partly dependent on the earnings of the patient when they died?

Wholly ☐ Mainly ☐ Partly ☐

**Surviving dependant 3**

Full name

Relationship to deceased | Age

Address

Postcode

Contact phone number (including area code)

Was this dependant wholly, mainly or partly dependent on the earnings of the patient when they died?

Wholly ☐ Mainly ☐ Partly ☐

If you need more space, provide a separate sheet with details.

For each surviving dependant, provide evidence to demonstrate they are a dependant. For example, this could include a statutory declaration from someone with knowledge of the situation (either a parent, family member or in the case of no family, a close contact).

**45** Were any of the dependants full-time students older than 16 but younger than 21?

No ☐ ***Go to 46***

Yes ☐ Give details below

**Full-time student 1**

Full name of dependant

Name of educational institution where they were a full-time student

Address of educational institution

Postcode

Contact phone number of educational institution (including area code)

**Full-time student 2**

Full name of dependant

Name of educational institution where they were a full-time student

Address of educational institution

Postcode

Contact phone number of educational institution (including area code)

**Full-time student 3**

Full name of dependant

Name of educational institution where they were a full-time student

Address of educational institution

Postcode

Contact phone number of educational institution (including area code)

If you need more space, provide a separate sheet with details.

Provide evidence of enrolment at educational institution for each person listed above.

***Go to 47***

**46** Did the patient have at least one surviving parent, non-dependant child or sibling at the time of their death?

No ☐ STOP This claim is not eligible under the COVID-19 Vaccine Claims Scheme. For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

Yes ☐ Give details below

**Parent, non-dependant child or sibling**

Full name

Medicare card number (if known)

Ref no.

**or**

Individual Healthcare Identifier (if known)

8 0 0 3 6 0

Relationship to deceased

Age

Address

Postcode

Contact phone number (including area code)

Provide evidence to demonstrate they are a surviving parent, non-dependant child or sibling. For example, this could include a statutory declaration from someone with knowledge of the situation (either a family member or in the case of no family, a close contact, this can not be the person listed above).

**47** **Read** this before answering the next question.

You may claim up to a maximum of $15,000 in funeral expenses where you can show evidence to support this cost (the funeral home may be able to provide you with sufficient evidence).

Are you claiming funeral expenses?

No ☐ ***Go to 50***

Yes ☐

**48** How much are you claiming for funeral expenses?

$

Provide evidence to support the funeral expenses.

**49** Do you agree that this figure does not include any amounts payable by a third-party payer, for example, through funeral insurance?

No ☐

Yes ☐

## Financial institution details

**50** Provide the details of where the payment of an eligible claim is to be made.

The account must be in the patient's or claimant's name or the estate of the deceased in the case of death. A joint account is acceptable.

Payments cannot be made to an account used exclusively for funding from the National Disability Insurance Scheme.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

## Proof of identity

**51** Individuals must provide the following to confirm their identity:

- 1 primary photographic document
- 2 secondary documents to show the use of their identity in the community.

**Primary documents**

The individual must provide one of the following:

- front and back of a current **Australian driver licence***, learner permit or provisional licence issued by a state or territory, showing signature and/or photo and the same name as claimed
- current **Australian passport***
- current **Australian visa***
- current **proof of age or photo identity card** issued by an Australian government agency in your name with photo and signature
- current **shooter** or **firearms licence** showing signature and photo (not minor or junior permit or licence)
- for persons aged under 18 with no other Primary Use in Community Documents, a current **student identification card** with photo or signature.

**Secondary documents**

The individual must provide 2 of the following:

- **Medicare card***
- **bank card/credit card** (front of card only)
- **enrolment with the Australian Electoral Commission**
- photo identity card issued:
  - to an officer by a police force
  - by the Australian Defence Force
  - by the Australian Government or a state or territory government.

* These documents can be checked using the Document Verification Service

- evidence of right to a **government benefit** (Centrelink or Veterans' Affairs)
- **credit reference check**
- **security guard** or **crowd control** photo licence
- **Australian secondary or tertiary student photo identity document**
- certified **academic transcript** from an Australian university
- **Aviation Security Identification Card/Maritime Security Identification card**
- **certificate of identity** issued by the DFAT
- **convention travel document secondary** (United Nations) issued by the DFAT
- **foreign government** issued documents (for example driver licence)
- **consular photo identity card** issued by the DFAT
- **trusted referees report/letter** on company letterhead from a trusted source (for example your GP)
- state/territory government rates assessment notice
- **Australian Taxation Office assessment notice**
- **Australian utility bill** (for example, gas, electricity) showing name and address
- **Australian Private Health Insurance card**.

If an individual provides one or more identity documents in a former name, they must also provide additional documents to verify their change in name.

**If providing an identity document in a former name**

The individual must provide one of the following:

- change of name certificate issued by the Australian Registry of Births, Deaths and Marriages (RBDM), or
- an Australian Marriage Certificate issued by a state or territory (church or celebrant- issued certificates are not accepted), or
- divorce papers issued by the family court, or a Deed Poll document.

## Checklist

**52** Tick which documents have been submitted with this form.

If you are not sure, check the question to see if a document/ evidence needs to be provided.

| | |
|---|---|
| **COVID-19 Vaccine Claims Scheme – Medical report (MO063)** form (refer to **question 22**)<br>MO063 **must** be submitted with this application | ☐ |
| Summary of injury (refer to **question 24**) | ☐ |
| Any other information you believe will assist in the assessment of this claim | ☐ |
| Proof of identity documents for the injured person (if you answered Yes at **question 6**) | ☐ |
| **COVID-19 Vaccine Claims Scheme – Authorising a person or organisation to act on your behalf (MO064)** form (if you answered Yes at **question 7**) | ☐ |
| Evidence of hospitalisation – needs to show what you were treated for and date of admission and discharge (if you answered Yes at **question 25**) | ☐ |
| Evidence to support the location of where the patient was when they suffered the Harm (refer to **question 26**) | ☐ |
| A copy of the death certificate (refer to **question 26**) | ☐ |
| A completed **COVID-19 Vaccine Claims Scheme – Third Party Payment Statement (MO066)** form (refer to **questions 33 to 40**) | ☐ |
| Evidence to support past lost earnings being claimed (refer to **question 33**) | ☐ |
| Evidence to support future lost earnings being claimed (refer to **question 34**) | ☐ |
| Evidence to support past out of pocket expenses being claimed (refer to **question 35**) | ☐ |
| Evidence to support future out of pocket expenses being claimed (refer to **question 36**) | ☐ |
| Evidence to support past paid attendant care services being claimed (refer to **question 37**) | ☐ |
| Evidence to support future paid attendant care services being claimed (refer to **question 38**) | ☐ |
| A separate statement with required details (refer to **question 39**) | ☐ |
| A separate statement with required details (refer to **question 40**) | ☐ |
| Proof of identity for the care recipient (refer to **question 40**) | ☐ |
| Evidence to demonstrate dependency of each surviving dependant (if you answered Yes at **question 44**) | ☐ |
| Evidence of enrolment at educational institution for each person listed (if you answered Yes at **question 45**) | ☐ |
| Evidence to demonstrate the person is a surviving parent, non-dependant child or sibling (if you answered Yes at **question 46**) | ☐ |
| Evidence to support the funeral expenses you want to claim (refer to **question 48**) | ☐ |

## Privacy notice

**53** The privacy and security of your personal information is important to us and is protected by law. We only share your information as outlined in this document or the COVID-19 Vaccine Claims Scheme policy, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacypolicy**

Services Australia's privacy policy, available on its website, contains information about:

- how to access and make corrections to any personal information held by Services Australia, and
- how to complain about a breach of the *Australian Privacy Principles or the Privacy (Australian Government Agencies – Governance) APP Code 2017*.

## Terms and conditions

If you choose not to submit the requested information in this claim form, or if you do not agree to the terms and conditions below, your claim under the Scheme will not be assessed.

**54 I declare that**:

- I have read the privacy notice on this page.
- the information I have provided in this form and in support of my claim is complete and correct.
- all supporting documents attached are true copies of the original documents.
- I have read and understand the COVID-19 Vaccine Claims Scheme policy.

**I understand that**:

- a number of Australian Government agencies, other organisations and persons are involved in the administration of the Scheme, including Services Australia, the Commonwealth Department of Health and Aged Care (the Department) and their contractors (including members of the Independent Expert Panel and other medical and legal professionals).
- Services Australia or others involved in the assessment of claims may request additional evidence or information from someone other than myself, including my treating service provider(s), my employer(s) or any other relevant person.
- I may be asked to provide more information or evidence in relation to my claim, or to attend an independent medical examination of me, within a specified timeframe. I understand that, if I fail to do so within that timeframe and without reasonable excuse:
  - my claim (or the part(s) of my claim) may be assessed in the absence of the requested information or evidence, or
  - if my claim cannot be assessed in the absence of that information or evidence, my claim (or the part(s) of my claim) may be suspended or rejected.
- I must inform Services Australia of any changes to the information submitted within 14 days of any changes or if I become aware of any inaccuracy in the information submitted.
- I should obtain professional or legal advice on the appropriate tax treatment of any payment I receive under the Scheme.
- if I receive compensation under the Scheme, I will be required to repay to the Commonwealth any compensation, damages or similar, or other monetary amounts, recovered from a third party in respect of the injury or other harm suffered.
- payments under the Scheme may affect other compensation payments I receive or have received. I should seek independent legal advice in respect of claiming under the Scheme if I have made a claim for compensation for the same or similar condition or injury under any other Commonwealth, State or Territory scheme.
- identification documents I provide to Services Australia will be checked with the issuing authority to confirm validity. In providing these documents, I consent to the agency validating the documents with the issuing authority
- giving false or misleading information to the Commonwealth is a serious offence.

**I authorise**:

- Services Australia, the Department (including the Therapeutic Good Administration) and their contractors (which includes the members of the Independent Expert Panel, as well as other medical and legal professionals) to collect, use and disclose:
  - any information they currently hold about me and which they may collect in the future which is relevant to assessing my claim, including my Australian Immunisation Register, Medicare and Centrelink, Pharmaceutical Benefits Scheme (PBS) and income information
  - all information about me that is provided or collected as part of my claim, or
  - information that is otherwise relevant to my claim,

  from and to:
  - each other
  - the Australian Taxation Office
  - the Australian Government Actuary
  - other Australian Government agencies
  - other non-government organisations and persons, including my treating health practitioner(s) and other health practitioner(s) (for example, a medical officer providing an independent opinion)
  - any medical indemnity insurer
  - any workers' compensation insurer, and
  - other insurers

  for the purposes of assessing or otherwise dealing with my claim. This includes information relating to:
  - the COVID-19 vaccine received
  - the injury or other harm suffered
  - any treatment received
  - amounts claimed under the Scheme
  - any amount paid by a third party in respect of the injury or other harm suffered, and
  - my income.
- other organisations and persons to disclose information about me to Services Australia, the Department, their contractors, any other Australian Government agency, and any other organisation or person which is relevant to or is required to assess my claim.
- Services Australia or the Department to disclose information about me to the Australian Health Practitioner Regulation Agency where it is appropriate to do so.

Claimant's signature

On completion, print and sign by hand.

Date (DD MM YYYY)

Reset form Print form

Australian Government
Services Australia

# COVID-19 Vaccine Claims Scheme – Third Party Payment Statement (MO066)

## When to use this form

Use this form to declare if you have, have not, or will receive third party payments for claim losses you are applying for under the COVID-19 Vaccine Claims Scheme (the Scheme).

We need this information to assess your claim. If you do not complete and return this form, your claim will be assessed solely on the information that has been provided.

## Important information

The Scheme gives people a way to seek compensation instead of going through legal proceedings.

You need to meet the following requirements to be eligible for a one-off payment under the Scheme.

You must have:

- received a Therapeutic Goods Administration (TGA) approved COVID-19 vaccine
- met the definition of harm, like one of the clinical conditions listed in the policy
- been admitted to hospital as an inpatient or claimed a waiver if seen in an outpatient care setting
- losses or expenses of $1,000 or more, not including pain and suffering, due to the COVID-19 vaccination.

A copy of the COVID-19 Vaccine Claims Scheme Policy 2021 is available on the Department of Health and Aged Care website, go to **health.gov.au**

## For more information

Go to **servicesaustralia.gov.au/covid19vaccineclaims** or call **1800 653 809** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Call charges may apply.

### Help in your language

We can translate documents you need for your claim for free.

To speak to us in your language call **131 202**.

Call charges may apply.

### Telephone Typewriter

If you have a hearing or speech impairment, you can call the **TTY Service** on **1800 810 586**. A TTY phone is required to use this service.

## Filling in this form

You can fill this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and complete it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

## Claimant's details

**1** Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

**2** Date of birth (DD MM YYYY)

**3** Postal address

Postcode

**4** COVID-19 Vaccine Claims Scheme reference number (if known)

A R N

**5** Have you received or are entitled to receive any third party payments in relation to your claim for any of the claim categories below?

- Past Out of Pocket Expenses
- Future Out of Pocket Expenses
- Past Lost Income
- Future Lost Income
- Paid Attendant Care
- Gratuitous Attendant Care
- Loss of Capacity to provide Domestic Services
- Pain and Suffering

No ☐ ***Go to 7***

Yes ☐ ***Go to 6***

MCA0MO066 2309

**6** I make the following declaration:

### Past Out of Pocket Expenses – clause 18(2)(c)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for past Out of Pocket Expenses.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for past Out of Pocket Expenses.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for past Out of Pocket expenses.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for past Out of Pocket Expenses.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for past Out of Pocket expenses.

**or**

☐ I am not claiming for this claim component.

### Future Out of Pocket Expenses – clause 18(4)(c)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for future Out of Pocket Expenses.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for future Out of Pocket Expenses.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for payments made for future Out of Pocket Expenses.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for payments made for future Out of Pocket Expenses.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for future Out of Pocket Expenses.

**or**

☐ I am not claiming for this claim component.

### Past Lost Earnings – clause 19(2)(f)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for past Lost Earnings.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for past Lost Earnings.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for past Lost Earnings.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for past Lost Earnings.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for past Lost Earnings.

**or**

☐ I am not claiming for this claim component.

### Future Lost Earnings – clause 19(4)(d)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for future Lost Earnings.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for future Lost Earnings.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for future Lost Earnings.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for future Lost Earnings.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for future Lost Earnings.

**or**

☐ I am not claiming for this claim component.

### Pain and Suffering – clause 20(2)(c)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for Pain and Suffering.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for Pain and Suffering.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Pain and Suffering.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for Pain and Suffering.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Pain and Suffering.

**or**

☐ I am not claiming for this claim component.

### Care Services – clauses 21(2)(b) and 21(6)(d)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for Gratuitous Attendant Care Services.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for past and/or future Gratuitous Attendant Care Services.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Gratuitous Attendant Care Services.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for Gratuitous Attendant Care Services.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Gratuitous Attendant Care Services.

**or**

☐ I am not claiming for this claim component.

### Paid Care Services – clauses 21(4)(b)

☐ I have not received any payments from a Third Party Payer, or am not aware of any entitlements to payments from a Third Party Payer, in relation to my claim for Paid Attendant Care Services.

**or**

☐ I have received the sum of $ _____ from

_____

which represents payments made for past and/or future Paid Attendant Care Services.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Paid Attendant Care Services.

**or**

☐ I am aware that I am entitled to receive payments from

_____

which represents compensation for Paid Attendant Care Services.

I declare that the sum of $ _____

has been deducted from the amount I have claimed for Paid Attendant Care Services.

**or**

☐ I am not claiming for this claim component.

## Claimant's declaration

**7** **I declare that**:

- the information I have provided in this form is complete and correct.

**I understand that**:

- giving false or misleading information is a serious offence.

Claimant's signature

On completion, print and sign by hand.

Claimant's name

_____

Date (DD MM YYYY)

__ __ __ __ __ __ __ __

## Returning this form

Return this form and any supporting documents by:

- **email** to **COVID19.vaccine.claims.scheme@servicesaustralia.gov.au**
  There may be risks with sending personal information through unsecured networks or email channels.
- post to
  Services Australia
  COVID-19 Vaccine Claims Scheme
  PO Box 1001
  TUGGERANONG ACT 2901

Reset form Print form