



Australian Government

Comcare

DIRECT PAYMENTS UPDATE

Forward this form to Comcare, GPO Box 9905 Canberra ACT 2601

Use BLOCK letters when filling out the form

All cases involving continuing payments must be regularly reviewed. The purpose of this form is to ensure that Comcare maintains correct details for your claim and to remind you to advise Comcare of events that may affect compensation benefits. To ensure that your fortnightly payments continue without interruption, you should return this form to Comcare as soon as possible.

PRIVACY INFORMATION

Your privacy is important to us. For information about how we handle your personal information, please visit www.comcare.gov.au/privacy or contact us on 1300 366 979 and request a copy of our Privacy Policy.

Comcare claim number	<input type="text"/>		
Family name	<input type="text"/>	Given name(s)	<input type="text"/>
Address	<input type="text"/>		
Home phone number	<input type="text"/>	Mobile phone number	<input type="text"/>
Have you changed your address in the past 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you changed your name within the past 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please show your former name below:
Family name	<input type="text"/>	Given name(s)	<input type="text"/>
Do you need someone to act on your behalf with Comcare?	<input type="checkbox"/>		
Representative's name	<input type="text"/>	Relationship to you	<input type="text"/>
Address	<input type="text"/>		
Contact number	<input type="text"/>	Date of birth (for identification)	<input type="text"/> / <input type="text"/> / <input type="text"/>

I declare that:

- > the information I have supplied on this form and any other attachment is true and accurate
- > I am aware that the information I have given is legally binding and the making of a false statement or false claim is punishable by law
- > I am aware that I must advise Comcare if my circumstances change.

Signature of claimant	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Signature of witness	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Full name and address of witness	<input type="text"/>		