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

Family name | Given name(s)

Address

Home phone number | Mobile phone number

Have you changed your address in the past 12 months? ☐ No ☐ Yes

Have you changed your name within the past 12 months? ☐ No ☐ Yes If yes, please show your former name below:

Family name | Given name(s)

Do you need someone to act on your behalf with Comcare?

Representative's name | Relationship to you

Address

Contact number | Date of birth (for identification) / /

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 | Date / /

Signature of witness | Date / /

Full name and address of witness