SPORTSCOVER™

Sportscover Australia Pty Ltd
A.C.N. 006 637 903
A.B.N. 43 006 637 903
AFS Licence No. 230914

SPORTING ACCIDENT CLAIM FORM
Please read this page first before completing the Claim Form

Dear Member,

Thank you for your Claim Form request. This letter contains important information relevant to your Claim. Please read it carefully and make sure you understand its contents.

WE REQUIRE THE CLAIM FORM TO BE RETURNED (**FULLY COMPLETED**) TO SPORTSCOVER WITHIN 120 DAYS OF YOUR INJURY. **DO NOT** WAIT UNTIL TREATMENT IS COMPLETE BEFORE SUBMITTING THE CLAIM FORM.

1. The Medical Report on page 10 must be completed by the main Doctor, Chiropractor, Physiotherapist or Dentist who is providing treatment for your injury.

2. For Claims under the "LUMP SUM" Net Loss of Income Benefit your Employer must complete the Employer's Statement on page 7 and forward it directly to Sportscover. A Return to Work Statement from your Employer is also required before processing can be completed. If you are self employed, the financial statement on page 8 showing income details must be completed by your Accountant.

3. Please send all original receipts for Non Medicare Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts.

4. We will commence working on your Claim immediately however, Claims cannot be settled (entitlements calculated) until all treatment relating to the injury has been completed, all accounts have been paid and refunds from your Private Health Insurer have been obtained. Claims for Loss of Wages will only be processed once we have been provided with a Return to Work date.

5. In most cases, there are varying Excesses on claims for Medical Expenses and an excess of varying periods on claims for loss of earnings. For precise details and information regarding Policy maximums and excesses, please contact your Club or Association.

6. Sportscover Australia values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement please visit our website at www.sportscover.com.

If you have any queries, please call us immediately.

CLAIMS HOTLINE: 1300 134 956
EMAIL: asiapac.claims@sportscover.com

Please send all claims correspondence to:

CLAIMS DEPARTMENT
SPORTSCOVER AUSTRALIA PTY LTD
Locked Bag 6003
Wheelers Hill VICTORIA 3150

MELBOURNE	271 – 273 Wellington Road, Mulgrave, VIC 3170	Ph: +61 (0)3 8562 9100	Fax: +61 (0)3 8562 9111
SYDNEY	Suite 103, 507 Kent Street, Sydney, NSW 2000	Ph: +61 (0)2 9268 9100	Fax: +61 (0)2 9268 9111
LONDON	LUC, 3 Minster Court, Mincing Lane, London EC3R 7DD	Ph: +44 (0)20 7398 4080	Fax: +44 (0)20 7398 4090
TORONTO	Suite 270, 33 Yonge Street, Toronto, Ontario, M5E1G4	Ph: +1 (416) 987 7595	Fax: +1 (416) 336 4608

Email - asiapac.claims@sportscover.com) **Website -** www.sportscover.com **Claims Hotline - 1300 134 956**

Underwriting Agency of the Year 2009

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Claim Form

PLEASE USE BLOCK LETTERS | ALL SECTIONS MUST BE COMPLETED

BEFORE YOU COMMENCE FILLING IN THIS FORM, PLEASE MAKE SURE YOU HAVE READ AND FULLY UNDERSTOOD THE DIALOGUE ON THE FRONT OF THE CLAIM FORM AS IT CONTAINS IMPORTANT INFORMATION RELATING TO YOUR CLAIM. IF YOU HAVE ANY QUESTIONS AT ALL ABOUT ITS CONTENTS OR MEANING, PLEASE CONTACT YOUR NEAREST SPORTSCOVER OFFICE.

PART 1 – CONTACT / CLAIMANT DETAILS

Name of Claimant ____________________ ____________________
Surname Given Names

Date of Birth ____/____/________ Sex **Male** **Female**

Occupation ____________________

Home Address ____________________

State ____________________ Post Code ____________________

Address for Correspondence ____________________

State ____________________ Post Code ____________________

Telephone (AH) ____________________ Telephone (BH) ____________________

Mobile ____________________ Email ____________________

Sport ____________________

Team/Club ____________________

Association (in full) ____________________

1. (a) Please give a full description of the circumstances of the accident which led to the injury.

____

____

____

(b) Please provide a copy of the teamsheet/scoresheet where the details of the accident have been recorded

(c) When did the injury occur? Date ____/____/____ Time ____________ am/pm

(d) Please provide the address of where the injury occurred ____________________

____________________ Post Code ____________________

2. (a) What injuries did you receive? ____________________

(b) When did you first consult a practitioner for this injury? ____________________

____

(c) Is treatment complete for this injury? **Yes** **No**

(If **No** please notify us in writing as soon as it is.)

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PART 1 – CONTACT / CLAIMANT DETAILS (continued)

3. Were you admitted to Hospital? **Yes** **No**

   If **Yes** Name of Hospital ______

   Address ______

   Post Code ______

   In Patient ☐ Out Patient ☐ Name of Attending Doctor ______

4. Are you now, or have you ever been, subject to or affected by other Injury or Disease, Deformity, Defect of Senses, Infirmity or Weakness? **Yes** **No**

   If **Yes**, please give details ______

5. Have you ever lodged a personal accident claim before **Yes** **No**

   If **Yes**, please give details ______

6. (a) Are you a member of a Private Health Insurance Fund? **Yes** **No**

   If **Yes**, please give details

   Fund Name ______ Member Number ______

   (b) If **Yes**, are you entitled to claim for any of the following benefits? **Yes** **No**

Private Hospital	☐	Physiotherapy	☐	Dental	☐
Chiropractic	☐	Ambulance	☐	Massage	☐

   Other ancillary services. Please give details ______

7. If you intend making a loss of wages claim, are you making or entitled to make a claim in respect of this injury for any of the following?

Sick Leave	**Yes**	**No**	Workers Compensation	**Yes**	**No**
Motor Government Benefits	**Yes**	**No**	Superannuation Life Insurance	**Yes**	**No**

   If **Yes**, please give details ______

PLEASE NOTE
Original receipts and all statements of any benefit received from any source must be sent to Sportscover as soon as possible. Failure to do so will result in Settlement Delays. E Please also remember to **inform us in writing when your treatment is complete**. This will also reduce delays in settlement of your claim.

PART 2 – SETTLEMENT DETAILS

NOTE: For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

☐ Mail cheque ☐ Direct bank deposit (*if **bank deposit**, please give details below)*

BANK NAME ____________________

BENEFICIARY NAME ____________________

BSB NUMBER ☐ ☐ ☐ ☐ ☐ ☐ *minimum 6 digits*

ACCOUNT NUMBER ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ *maximum 9 digits*

PART 3 – DECLARATION AND AUTHORISATION BY INJURED PERSON

Name ____________________ ____________________
Surname *Given Names*

I hereby authorise any hospital, physician or other persons who have attended me, or any employer, to furnish Sportscover Australia Pty Ltd or their authorised representative with any illness or injury, medical history, consultation, prescriptions or treatment, copies of hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Signature Date / /

WARNING: Persons found to have lodged a fraudulent claim are liable for prosecution.

PART 4 – WITNESS STATEMENT - We require a statement from anyone who witnessed the incident. Please have that person/s complete this section.

1. (a) Name ______________________ ______________________
   Surname *Given Names*

   (b) Address ____

   ______________________ State __________ Postcode __________

   (c) Telephone (AH) ______________________ Telephone (BH) ______________________

   (d) Please give a full description of the accident giving a rise to the claimant's injury, as you saw it:

   ____
   ____
   ____
   ____
   ____
   ____

   Signature of Witness Date / /

2. (a) Name ______________________ ______________________
   Surname *Given Names*

   (b) Address ____

   ______________________ State __________ Postcode __________

   (c) Telephone (AH) ______________________ Telephone (BH) ______________________

   (d) Please give a full description of the accident giving a rise to the claimant's injury, as you saw it:

   ____
   ____
   ____
   ____
   ____
   ____

   Signature of Witness Date / /

PART 5a – DETAILS OF EMPLOYMENT
Complete this section only if you wish to CLAIM FOR LOSS OF EARNINGS.

PLEASE NOTE:

- A claim cannot be made unless the claimant was gainfully employed and working at least 20 hours a week at the date of injury.
- The Claimant must be continuously and totally disabled for more then the excess period noted in the Policy.
- The initial week of disablement is not covered.

Current Employer's Name ______________________

Current Employer's Address ______________________

______________________ State __________ Postcode __________

Contact Name ______________________

Telephone (AH) ______________ Telephone (BH) ______________

1. At the time of the accident were you *(please select as appropriate)*

   ☐ Full Time Employee

   ☐ Part Time Employee Working ________ hours per week

   ☐ Self Employed on a full time basis ______________________

   Period of Employment ____/____/________

2. What is your Occupation/Position? ______________________
3. What are your net Earnings per annum from this employer? ______________________
4. When did you cease work as a result of your injury? ____/____/________
5. Have you returned to work? **Yes** **No** *If **Yes**, when?* ____/____/________

   ____

6. Please give details of your entitlements (if any) to each of the following benefits:

	Number of Weeks		Weekly Amount		Total Entitlement
(a) Sick pay from your employer	________	@	________	=	________
(b) Other insurance benefits including Personal Accident Policies	________	@	________	=	________
(c) Centrelink	________	@	________	=	________
(d) Other salary, wages, income or pay of any nature whatsoever being:	________	@	________	=	________
If other sources, please describe briefly. ________					
			Total Entitlements	=	________

7. What was your income from all sources in the twelve months period prior to your accident? **Total Annual Income from all sources** = ________

PART 5a – DETAILS OF EMPLOYMENT Continued.

8. Have you worked at more than one place of employment within the twelve month period prior to your accident? **Yes** **No**

   *If **Yes**, please provide details below showing full names and addresses – no abbreviations.*

   (a) **Former Employer**

   Contact ______________________ Telephone (BH) ______________________

   Address ____

   ______________________ State ______________ Postcode ________

   Occupation / Position ______________________________________

   Period of Employment ____/____/____ to ____/____/____

   (Please list any additional former employers on a separate list. Leave blank if not applicable.)

PART 5b – EMPLOYER'S STATEMENT - To be completed by Claimant's current Employer

I ______________________________ **Manager** **Accountant** **Director** **Partner**
(Name) *please select title*

of ____
(Name of Company)

at ______________________________ State ______________ Postcode ________

confirm that ______________________________ has been employed continuously by
(Name of Employee)

this firm in the position of ______________________________ since ____/____/____

His/Her gross earnings since the above date of employment (if less than 12 months ago) or for the past 12 months up to the date of his/her injury as described on this claim form amounted to $ ______________

At the ____/____/____ , the claimant was entitled to ____________ sick days pay.
(Date of Injury)

I confirm that the claimant was not entitled to receive, nor did receive any form of remuneration whatsoever from this firm, his employer, in respect of his/her period of disablement commencing at the above-mentioned date of injury; except as follows:

____

____

Signature ______________________ Date ____/____/____

PART 5c – ACCOUNTANT'S STATEMENT
To be completed by Claimant's Accountant – For Self Employed Person's Only

I ______________________________ **Manager** **Accountant** **Director** **Partner**
(Name) *please select title*

of ____
(Name of Company)

at ______________________________ State __________ Postcode __________

confirm that our firm acts as Accountants for ______________________________
(The Claimant)

at ______________________________ State __________ Postcode __________

and that his/her gross earnings (before tax but after expenses) for the 12 months period ending ___ / ___ / ___
(Date of Injury)

amounted to $ __________ .

Income protection **Yes** **No** *If **Yes**, name of company* ______________________________

Signature Date / /

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Official Report

PLEASE USE BLOCK LETTERS | PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED

PLEASE NOTE:
These questions must be completed by an authorised office bearer of the insured Club/Association.
The Team sheet or Injury Report is a separate document.

PART 6 – INCIDENT REPORT

CLAIMANT'S NAME ______________________________

Date of Injury ____ / ____ / ____

1. Name of Association ______________________ Club ______________________
2. Was the player, listed above, registered at the time of the accident? **Yes** **No**
3. Were you a witness to the accident described *(If* ***Yes****, please give details)* **Yes** **No**

____

____

____

____

If you were not a witness, are you satisfied the player was injured on the above date whilst participating in a club game or training session? **Yes** **No**

If **No**, please give reasons ______________________________

____

____

PART 7 – DECLARATION BY AN AUTHORISED OFFICE BEARER

I certify that the particulars shown on this form are, to the best of my knowledge, true and correct and hereby authorise this claim to be paid directly to ______________________ *(claimant)*.

Signature ______________________ Date ____ / ____ / ____

Print Name ______________________________

Position ______________________________

Address ______________________ Telephone ______________________

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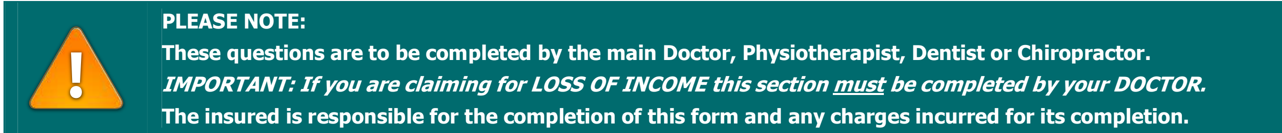
Medical Report

PLEASE USE BLOCK LETTERS | PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED



PLEASE NOTE:
These questions are to be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor.
IMPORTANT: If you are claiming for LOSS OF INCOME this section must be completed by your DOCTOR.
The insured is responsible for the completion of this form and any charges incurred for its completion.

PART 8 – MEDICAL REPORT

Patient's Details

Name ______________________ ______________________
Surname *Given Names*

Address ____

______________________ State __________ Postcode ______

Telephone (AH) ______________ Telephone (BH) ______________

What is disabling the patient? *(Please give a complete diagnosis of this condition)*

____

____

History

1. When did the patient first receive medical treatment for this injury? ____/____/____
2. (a) Was there a previous history of this or similar condition? **Yes** **No**
   (b) *If **Yes**, please state the condition and advise when previous treatment was given* ______________

   ____
3. (a) How long have you known the patient? ____/____/____
   (b) Are you the claimant's regular practitioner? **Yes** **No**
   (c) *If **No**, please advise who is* ______________________

Injury

1. When did the patient suffer the injury ____/____/____
2. What were the circumstances surrounding the injury? ______________________

   ____

   ____

   ____

Degree of Disability

1. Patient's Occupation ______________________
2. When was the patient obliged to cease work? ____/____/____
3. If patient is still disabled, when approximately will the patient resume:
   (a) Some duties? ____/____/____ (b) Full duties? ____/____/____
4. If patient has recovered, when was the patient able to resume:
   (a) Some duties? ____/____/____ (b) Full duties? ____/____/____

Treatment of present condition

1. When were you consulted? (a) Initially ____/____/____ (b) Most recently ____/____/____
2. How often has the patient consulted you? ______________________

PART 8 – MEDICAL REPORT – Continued.

3. Was patient confined to hospital? **Yes** **No**
4. *If* ***Yes****, please advise* (a) Name of hospital ______
   (b) Period of Confinement from ___/___/___ to ___/___/___
5. Was confinement in a convalescent home necessary after hospitalisation **Yes** **No**
   If ***Yes****, please give details* ______
6. What are the current subjective symptoms? ______
7. Please give results of any objective findings:
   (a) X-Rays ______
   (b) Other tests – *please advise tests done and findings* 1. ______
   2. ______
8. What surgical procedures have been performed? ______
9. What surgical procedures have been contemplated? ______
10. Are there any underlying conditions affecting recovery from the current condition? **Yes** **No**
    If ***Yes****, could you advise the nature of underlying conditions and how they affect disability and recovery:*
    ______
11. Has patient any other physical or mental impairment? **Yes** **No**
    If ***Yes****, please describe* ______
12. Please advise names and addresses of other treating physicians
    Name ______
    Address ______
    ______ Telephone ______
13. If you have terminated treatment, please advise date ___/___/___
14. What is the current prognosis? ______
15. Are there any further remarks which may assist in assessing this condition? ______
    ______
16. Is there any permanent disability at present? **Yes** **No**
    If ***Yes****, please explain giving an estimated percentage loss of function:* ______
    ______

Physician's Details

Full Name ______
Qualifications ______
Street Address ______
Suburb ______ State ______ Postcode ______
Telephone ______ Email ______
Website ______
Signature ______ Date ___/___/___

206 Health Insurance Act 1973

Medical Expenses

(Australian government legislation (see below) ***does not allow*** General Insurers to cover ***any costs*** subject to a Medicare rebate.)

Examples of Medicare Medical Expenses (Excluded from Policy) **(Figures used are for example purposes only)**	
Private Practitioner Visit (GP) - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $50.00 Medicare Rebate: $35.00 Balance: $15.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Surgeon - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $750.00 Medicare Rebate: $600.00 Balance: $150.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Anaesthetist - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $400.00 Medicare Rebate: $300.00 Balance: $100.00 (Not Claimable)	Medicare Item – not covered in part or whole.
Public Hospital Accommodation - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $400.00 Medicare Rebate: $325.00 Balance: $75.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Examples of Medical Services which may be covered by the Sportscover Policy	
Private Hospital Accommodation , Private Hospital Theatre Fees, Ambulance	Refer to policy for limits.
Physiotherapy, Chiropractor, Massage, Acupuncture, Myotherapy, Osteopath, Hydrotherapy, Podiatry	Refer to policy for limits.
Dental (Sound Whole Teeth Only), MRI's (under certain conditions)	Refer to policy for limits.
Hire of Crutches, Wheelchair, Equipment for Rehabilitation, Brace	Refer to policy for limits.
The policy relevant to your Club or Association will have a specific **Excess, Maximum Percentage Payable and a Maximum Limit Payable.** For the specific policy benefits please refer to your Claims covering letter and policy wording which details the policy benefits, coverage and conditions.	

206 Health Insurance Act 1973

Part VII – Miscellaneous

Prohibition of certain medical insurance.

126 (1) A person shall not make a contract of insurance with another person that contains a provision purporting to make the first mentioned person liable to make a payment in the event of the incurring by the other person of a liability to pay medical expenses in respect of the rendering in Australia of a professional service for which Medicare benefit is, or but for subsection 18(4) would be payable.

Penalty $1000.

(2) Where there is contract of insurance (whether made before or after the commencement of this section) under which the insurer is liable to make a payment in the event of the incurring by that person of liability to pay medical expenses in respect of the rendering in Australia of a professional service, there is an implied condition in the contract that the insurer is not liable for loss arising out of the incurring of liability to pay medical expenses in respect of the rendering in Australia of a professional service in respect of which a Medicare benefit is, or but for subsection 18(4) would be, payable.

(3) Where:
- (a) the proper law of a contract of insurance would, but for a term that it should be the law of some other country or a term to the like effect, be part of the law of any part of Australia; or
- (b) a contract of insurance contains a term that purports to substitute, or has the effect of substituting, provisions of the law of some other country or of a State or Territory for all or any of the provisions of this section;

this section applies to the contract notwithstanding that term.

(4) Any term of a contract of insurance (including a term that is not set out in the contract but is incorporated in the contract by another term of the contract) that purports to exclude, restrict or modify or has the effect of excluding, restricting or modifying the application in relation to that contract of all or any of the provisions of this section is void.

(5) A term of a contract shall not be taken to exclude, restrict or modify the application of a provision of this section unless the term does so expressly or is inconsistent with that provision.

(5A) This section does not apply in relation to a contract of insurance entered into by a registered organization as insurer in so far as the contract provides for benefits in accordance with the basic table.