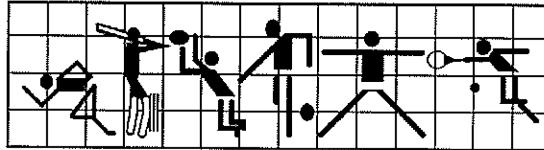


SPORTSCOVER

QUALITY INSURANCE AT A SPORTING PRICE

A.C.N. 006 637 903
A.F.S. Licence No.230914

CLAIM FORM

Dear Member,

IMPORTANT INFORMATION, relevant to YOUR Claim, is contained on this page of the Claim Form and the enclosed Policy Wording. PLEASE read them and make sure you understand their contents.

IT IS IMPORTANT.

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 Physician's Statement 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 and forward it directly to Sportscover. If you are self employed, the financial statement showing income details must be completed by your Accountant. A Return to Work Statement from your Employer is also required before processing can be completed.

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. 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.

If you have any queries, please call us immediately.

CLAIMS DEPARTMENT
SPORTSCOVER AUSTRALIA PTY.LTD.
A.C.N. 006 637 903

CLAIMS HOTLINE: 1300 134 956

SPORTSCOVER AUSTRALIA PTY LTD A.C.N. 006 637 903 AFS Licence No 230914

MELBOURNE	271 – 273 Wellington Road, Mulgrave, Vic. 3170	Ph: +61 3 8562 9100	Fax: +61 3 8562 9111
SYDNEY	Suite 1, Level 2, 68 Macquarie Street, Parramatta, NSW 2150	Ph: +61 2 8833 5800	Fax: +61 2 8833 5811
LONDON	LUC, 3 Minster Court, Mincing Lane, London, EC3R 7DD	Ph: +44 (0)20 7398 4080	Fax: +44 (0)20 7398 4090

EMAIL: info@sportscover.com WEBSITE: www.sportscover.com

SPORTING ACCIDENT CLAIM FORM

<u>All Sections Must Be Completed</u>

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 relevant to your claim. If you have any questions at all about its contents or meaning, please contact your nearest Sportscover Office.

SPORT :

Name of Claimant..
Surname *Given Names*

Address for Correspondence...

.... State .... Post Code ....

Telephone (AH) .... (BH) .... FAX ....

Internet Email ....

Internet Site ....

Team/Club .... Association *(in full)* ....

Date of Birth ..../............/............ SEX: Male (............) Female (............)

Occupation: ....

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 **<u>teamsheet/scoresheet</u>** 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 not, please notify us in writing as soon as it is.)

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) Are you entitled to claim for any of the following benefits? Yes (...............) No (..............)

Private Hospital ( ) Physiotherapy ( ) Dental ( )

Chiropractic ( ) Ambulance ( ) Massage ( )

Other ancillary procedures. Please give details ....

7. 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 ....

....

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

NOTE: Once your claim has been settled, we can, if you wish, transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no cheque clearance delays. If you wish to avail yourself of this service, please provide us with the following details of your bank account.

BANK NAME ....

BENEFICIARY NAME ....

BSB NUMBER ☐☐☐☐☐☐ minimum 6 digits

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

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.

Date ..../........./......... Signature ....

We require a statement from anyone who witnessed your accident. Please have that person complete this section.

Name..

Address...

Telephone (AH) .... (BH) ....

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

....

....

....

Signature.. Date.........../.........../..........

COMPLETE THIS SECTION ONLY IF YOU WISH TO CLAIM FOR LOSS OF EARNINGS

Employer's Name..

Employer's Address...

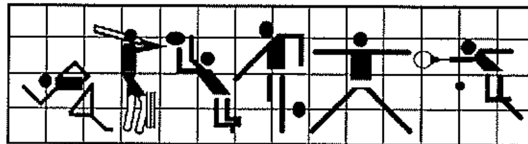
.... State... Post Code..................

1. Are you Full Time (..........)

   Part Time (..........) Working .... Hours Per Week

   Self Employed (..........)

2. What is your Occupation? ....
3. What are your net Earnings per annum? ....
4. When did you cease work as a result of your injury? ....
5. Have you returned to work? If so, when? .... Date ..../.........../...........



SPORTSCOVER

QUALITY INSURANCE AT A SPORTING PRICE

A.C.N. 006 637 903
A.F.S. Licence No. 230914

Office Use Only:

Claim No: …………………

OFFICIAL REPORT

(These questions must be completed by an authorised office bearer of the insured club/association)
(NOTE, THE TEAMSHEET OR INJURY REPORT IS A SEPARATE DOCUMENT)

(Please ensure that all questions have been fully answered)

CLAIMANT'S NAME: ____

DATE OF INJURY: _____/_____/_____

1. Name of Association…………………………………………….Club……………………………………………………

   Team ………………………………………… grade .... player was playing in at the time of accident.

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 ....

....…

....…..

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?

....…….

If not, please provide details which outline your concern...……..

....…

....…

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).

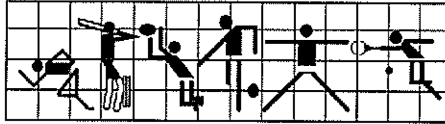
Signed.. Print Name……………………………………..

Position…………………………………………….

Address……………………………………………………………………………Tel: ( )……………………………………

SPORTSCOVER AUSTRALIA
271-273 Wellington Road
Mulgrave, VIC 3170
PH: (03) 8562 9100
FAX: (03) 8562 9111
Email: info@sportscover.com
Website: http://www.sportscover.com

CLAIMS HOTLINE: 1300 134 956



SPORTSCOVER

QUALITY INSURANCE AT A SPORTING PRICE

A.C.N. 006 637 903
A.F.S. LICENSE No. 230914

Office Use Only:

Claim No: ……………….

SECTION 5 DETAILS OF EMPLOYMENT

(To be completed only if you intend to claim for the Lump Sum Net Loss of Income benefit)

NOTE:

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

At the time of the accident were you - (please circle as appropriate)

* A full - time employee?
* Part - time employee working .... hours/week?
* Self - employed on a full - time basis?

Name .... Address ....

.... State .... Post Code ....

a) Please give details of your entitlement (if any) to any of the following benefits:

	No. of weeks		Weekly Amount		Total Entitlement
(i) Sick-pay from your employer		@		=	
(ii) Other insurance benefits including Personal Accident Policies		@		=	
(iii) Other salary, wages, income or pay of any nature whatsoever being		@		=	
			TOTAL	=	

What was your income from all sources in the twelve months period prior to your accident?

Total Annual Income from all Sources - $ ....
If an employee -

Name and address of your employer or employers during the twelve month period prior to your accident.
(Please show full names and address - no abbreviations)

Current Employer .... Contact ....……….

Address ....…..

Period of employment .... to .... Phone No ....……

Occupation/Position ……..

Former Employer .... Contact ....

Address ....…

Period of employment .... to .... Phone No ....

Occupation/Position ……

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

EMPLOYER'S STATEMENT

To be completed by Claimants current Employer

I .... MANAGER/ACCOUNTANT/DIRECTOR/PARTNER

of ....of .... confirm that
(Name of Firm) (Address)

.... has been employed continuously by 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:

....

....

....

Signed .... Witness ....

ACCOUNTANTS STATEMENT - Self employed persons only.

To be completed by the Claimant's Accountant

I .... MANAGER/ACCOUNTANT/DIRECTOR/PARTNER

of .... of .... confirm that
(Name of Firm) (Address)

our firm act as Accountants for .... of
(The Claimant)

.... and

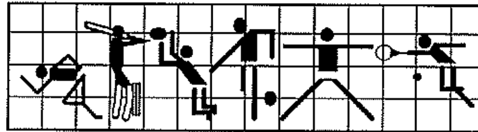
that his/her gross earnings (before tax but after expenses) for the 12 months period ended .... / .... / ....
(Date of Injury)

amounted to $ .... Income Protection Yes ☐ No ☐ Name of Company..

SIGNATURE .... WITNESS ....

ATTENDING PHYSICIAN'S STATEMENT

To be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor



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A.C.N 006 637 903

A.F.S. License No. 230914

CLAIMS HOTLINE
1300 134 956

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Office Use Only

CLAIM NUMBER ....

PATIENT'S NAME AND ADDRESS..

....

WHAT IS DISABLING PATIENT?..

Please give a complete diagnosis of this condition: ....

....

....

HISTORY:

1. When did patient first receive medical treatment? ..../........../..........

2. (a) Was there a previous history of this or similar condition? Yes ☐ No ☐
   (b) If Yes, please state condition and advise when previous treatment was given.........................

....

....

3. (a) How long have you known the patient? ..../........../..........
   (b) Are you the regular general practitioner? Yes ☐ No ☐
   If not, please advise who is ....

IF INJURY:
1. When did patient suffer injury? ....
2. What were the circumstances surrounding the injury? ....

IF SICKNESS:
1. When was sickness first contracted?..
2. When did symptoms become evident?...

DEGREE OF DISABILITY:
1. Patient's Occupation?..
2. When was 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?...

3. Was patient confined to hospital? Yes ☐ No ☐

If yes, please advise 1. Name and/ of hospital ....

2. Period of Confinement From ..../........./......... To ..../........./.........

4. Was confinement in a convalescent home necessary after hospitalisation Yes ☐ No ☐

If Yes, give details..

5. What are the current subjective symptoms? ....

6. Please give results of any objective findings

1. X-Rays

2. Other Tests-Please advise tests done and findings 1. ....

2. ....

7. What surgical procedures have been performed ....

....

8. What surgical procedures are contemplated ....

....

Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐

If yes, could you advise nature of underlying conditions and how they affect disability and recovery ....

....

Has patient any other physical or mental impairment? Yes ☐ No ☐

If yes, please describe..

....

Please advise names and addresses of other treating physicians...

....

If you have terminated treatment, please advise date ..../........./..........

What is the current prognosis? ....

....

....

Are there any further remarks which may assist in assessing this condition?...

....

....

Is there any permanent disability at present? Yes ☐ No ☐

If yes, please explain giving estimated percentage loss of function ....

....

DATE: SIGNATURE: DEGREE:

Name: (Please Print) ______________________________

Street Address ______________________________

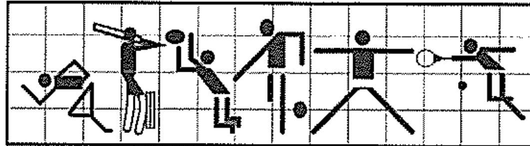
City or Town ______________________ **State** __________ **Phone No.** ______________

Internet Email ______________________ **Internet Site** ______________________

SPORTSCOVER AUSTRALIA PTY LTD A.C.N. 006 637 903 AFS Licence No 230914

MELBOURNE	271 – 273 Wellington Road, Mulgrave, Vic. 3170	Ph: +61 3 8562 9100	Fax: +61 3 8562 9111
SYDNEY	Suite 1, Level 2, 68 Macquarie Street, Parramatta, NSW 2150	Ph: +61 2 8833 5800	Fax: +61 2 8833 5811
LONDON	LUC, 3 Minster Court, Mincing Lane, London, EC3R 7DD	Ph: +44 (0)20 7398 4080	Fax: +44 (0)20 7398 4090

EMAIL: info@sportscover.com WEBSITE: www.sportscover.com



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A.F.S. License No. 230914

MY SPORTSCOVER FOLLOW UP SHEET

THIS IS DESIGNED TO HELP YOU AND THE SPORTSCOVER CLAIMS DEPARTMENT IN MAKING SURE THAT YOUR CLAIM IS HANDLED QUICKLY AND EFFICIENTLY FOR AN EARLY SETTLEMENT. ENQUIRIES CAN BE MADE BY CONTACTING THE CLAIMS DEPARTMENT HOTLINE ON 1300 134 956.

☑ E.G. I have received a claim form

☐ Sent my Sportscover Claim Form back within 120 days of my injury to **Claims Department**
271-273 Wellington Road,
Mulgrave, Vic 3170

THE FOLLOWING REQUIREMENTS ARE TO BE RETURNED WITHIN 12 CALENDAR MONTHS FROM THE DATE OF THE INJURY............

Receipts and/or statements from Private Health Insurance ☐

Obtained a Doctors Referral ☐

Notified Sportscover in writing when all my treatment is complete ☐

IF CLAIMING FOR LOSS OF INCOME

Employment Declaration form completed by Employer and sent to Sportscover within 120 days of my injury ☐

206 Health Insurance Act 1973

Si 126

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

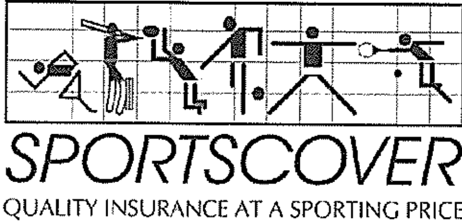
(b) a contract of insurance contains a term that purports to substitute, or has the effect of substituting, provisions of the law of some other country or of a State or Territory for all or any of the provisions of this section;

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.



Privacy and Insurance at Sportscover Australia

Proposal, Renewal, Endorsement and Claim forms

Sportscover and its agents are bound by the obligations of the **Privacy Act 1988 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act)** and will be covered by the **General Insurance Information Privacy Code (the Code).** These set basic standards relating to the collection, use, disclosure and handling of personal information.

'Personal information' is essentially information or an opinion about a living **individual** whose identity is apparent or can reasonably be ascertained from the information or opinion.

Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives).

Only information necessary for the arrangement and administration of Sportscover's business by Sportscover, its Brokers or agents and their representatives will be collected. This includes information necessary to accept the risk, to assess a claim, to determine competitive and appropriate premiums.

Sportscover and its Brokers or agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Sportscover and its Brokers or agents personal information about other individuals, we rely on you to have made or make them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by Sportscover by contacting your Broker or contacting Sportscover directly, by any of the following:

Phone: (03) 8562 9100
61 3 8562 9100 (International)
Fax: (03) 8562 9111
Email: privacy@sportscover.com