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

SPORTSCOVER™ • Melbourne • Sydney • London • Shanghai •
Melbourne: 271-273 Wellington Rd, Mulgrave
Locked Bag 6003, Wheelers Hill, VIC 3150
T: +61 (0)3 8562 9100 F: +61 (0)3 8562 9111
Claims Hotline: 1300 134 956 (Aust Only) **Email:** asiapac.claims@sportscover.com
ACN 006 637 903 ABN 43 006 637 903 AFS Licence Number 230914
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25 YEARS OF INSURING SPORT

Underwriting Agency of the Year Inaugural Winner

sportscover.com

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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 ________________

Australian Permanent Resident **Yes** **No** **Other** *(if other, please specify)* : ________________

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 ________

(e) At the time of the injury, were you:

Playing	☐	Training	☐	Social Game/Match	☐
Pre Season Playing	☐	Pre Season Training	☐	Officiating	☐
Other	☐				

If "Other", please provide details ________________________________

PART 1 – CONTACT / CLAIMANT DETAILS – continued...

(f) On what surface were you participating?

Grass	☐	Synthetic Surface	☐	Wooden Floor	☐
Gravel	☐	Concrete/Bitumen	☐	Other	☐

If "Other", please provide details ______________________

(g) What was the condition of the surface?

Normal	☐	Hard	☐	Wet	☐
Muddy	☐	Other	☐		

If "Other", please provide details ______________________

(h) What were the weather conditions at the time of injury?

Fine	☐	Light Rain	☐	Heavy Rain	☐
Other	☐				

If "Other", please provide details ______________________

(i) What were the temperature conditions at the time of injury?

Very Hot	☐	Hot	☐	Hot & Humid	☐
Mild	☐	Cold	☐	Very Cold	☐
Other	☐			Cold	

If "Other", please provide details ______________________

(j) What activity lead to the injury?

Landing	☐	Jumping	☐	Twist/Turn	☐
Side Stepping	☐	Starting	☐	Stopping	☐
Running	☐	Kicking	☐	Tackle	☐
Impact by Object	☐	Collision with Player	☐	Other	☐

If "Other", please provide details ______________________

(k) Was a sports trainer present at the game? **Yes** **No** **Unknown**

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.)

PART 1 – CONTACT / CLAIMANT DETAILS – continued…

3. Were you taken to hospital by Ambulance? **Yes** **No**

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

If **Yes** Date from / / to / /

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**

Income Protection (*for example: Personal or via Superannuation Fund)* **Yes** **No**

Centrelink Sickness **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. 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, medical practitioner, medical specialist or any other person who has attended me and/or any employer of mine, past or present, to furnish Sportscover Australia Pty Ltd (SCA) and/or its representatives with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers including verification of my earnings.

I acknowledge that any personal information that I have or will provide to Sportscover Australia Pty Ltd (SCA) is necessary for and will be used in the processing, assessing, investigation or review of this claim. I hereby authorise SCA and/or its representatives and consent to SCA and/or its representatives and/or its authorised agent to disclose my personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed/authorised broker, account broker and/or broker of the entity/body corporate/organisation insured (Insured), State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personal information (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, I can contact the SCA Privacy Officer.

I agree that a photocopy/scanned copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

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.

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 Tax File Number ____________________

☐ Part Time Employee Working ________ hours per week

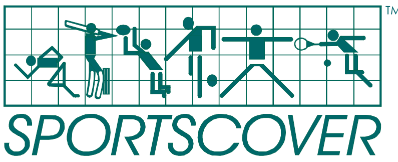
☐ Self Employed on a full time basis ____________________

Period of Employment ____ / ____ / ____ ABN ____________________

It is a requirement of the Australian Tax Office (ATO) that insurers withhold PAYG tax when you are claiming loss of income. Can you please complete and return the attached Tax File Number (TFN) Declaration. This is important so that we can calculate the correct amount of withholding tax. Non-receipt of a TFN will result in tax being withheld from the payment at the top marginal rate currently (49%).

If you hold an ABN, you are not required to complete and return the Tax File Number Declaration (TFN). However, you will need to provide us with your ABN details. This may apply to the self-employed or people who are involved in businesses.

Please contact our office should have any queries.



2. What is your Occupation/Position? ______________________

3. What are your Gross 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 (eg: President, Treasurer, Secretary).
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 ____________________

Suburb ____________________ State __________ Post Code __________

Policy Number ____________________ 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, MRI's ______________________
   (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.