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

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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 _____

Suburb 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.)

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**
Income Protection	**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 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 _____

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 _____
   (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.