

## 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](http://www.sportscover.com).

If you have any queries, please call us immediately.

**CLAIMS HOTLINE: 1300 134 956**

**EMAIL: [asiapac.claims@sportscover.com](mailto:asiapac.claims@sportscover.com)**

Please send all claims correspondence to:

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

**MELBOURNE  
SYDNEY  
LONDON  
TORONTO**

271 – 273 Wellington Road, Mulgrave, VIC 3170  
Suite 103, 507 Kent Street, Sydney, NSW 2000  
PO Box HQ 420, 3rd Floor, St Helen's, 1 Undershaft, London, EC3P 3DQ  
Suite 270, 33 Yonge Street, Toronto, Ontario, M5E1G4  
Email - [asiapac.claims@sportscover.com](mailto:asiapac.claims@sportscover.com) Website - [www.sportscover.com](http://www.sportscover.com)

Ph: +61 (0)3 8562 9100 Fax: +61 (0)3 8562 9111  
Ph: +61 (0)2 9268 9100 Fax: +61 (0)2 9268 9111  
Ph: +44 (0)20 7398 4080 Fax: +44 (0)20 7398 4090  
Ph: +1 (416) 987 7595 Fax: +1 (416) 336 4608  
**Claims Hotline - 1300 134 956**



**Underwriting Agency of the Year 2009**

## 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.)

**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 \_\_\_\_\_

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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 \_\_\_\_\_

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

If **Yes**, please give details \_\_\_\_\_

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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 <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>	Dental <input type="checkbox"/>
Chiropractic <input type="checkbox"/>	Ambulance <input type="checkbox"/>	Massage <input type="checkbox"/>

Other ancillary services. Please give details \_\_\_\_\_

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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	<b>Yes</b>	<b>No</b>	Workers Compensation	<b>Yes</b>	<b>No</b>
Motor Government Benefits	<b>Yes</b>	<b>No</b>	Superannuation Life Insurance	<b>Yes</b>	<b>No</b>
Income Protection	<b>Yes</b>	<b>No</b>	Centrelink Sickness	<b>Yes</b>	<b>No</b>

If **Yes**, please give details \_\_\_\_\_

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**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:

	<b>Number of Weeks</b>		<b>Weekly Amount</b>		<b>Total Entitlement</b>
(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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 \_\_\_\_\_



# 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 \_\_\_\_\_



**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.)

<b>Examples of Medicare Medical Expenses (Excluded from Policy)</b> <b>(Figures used are for example purposes only)</b>	
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.
<b>Examples of Medical Services which may be covered by the Sportscover Policy</b>	
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 <b>Excess, Maximum Percentage Payable and a Maximum Limit Payable</b> . 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.