SPORTING ACCIDENT CLAIM FORM

PLEASE READ THIS FIRST PAGE BEFORE COMPLETING THE 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 RECOMMEND THAT YOU RETURN YOUR CLAIM FORM 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 copies of all receipts for Non Medicare Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts. Please note that we do not post back original 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.

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 on 1300 134 956

PLEASE SEND ALL CORRESPONDENCE TO:
Claims Department
Sportscover Australia Pty Ltd
Locked Bag 6003
Wheelers Hill, Victoria 3150

OR **EMAIL: claims@sportscover.com**

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FOOTBALL FEDERATION AUSTRALIA

FOOTBALL FEDERATION AUSTRALIA
SPORTING ACCIDENT CLAIM FORM

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

First Name of Claimant

Surname of Claimant

Sport FOOTBALL (SOCCER)

Type PLEASE SELECT

Name of Team/Club

Association (In full)

FFA Number

Address for Correspondence

State Post code

Telephone *(AH)*

Telephone *(BH)*

Mobile

Email Address

Fax

Date of Birth / /

Occupation

Occupation Description PLEASE SELECT

Australian Permanent Resident? Yes No

Other (Please Specify)

AUTHORITY TO ACT ON YOUR BEHALF:

If you wish to give authority for another person to act on your behalf in respect to this claim you must complete the following details (otherwise we will not be able to give any information about your claim to any other person).

I/We authorise (name)

Of (address)

State Post code

Relation

Telephone *(BH)*

Mobile

Email

Date of Birth / /

PART 2: INJURY / INCIDENT DETAILS

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 team-sheet / score-sheet where the details of the accident have been recorded.

(c) When did the injury occur? ☐☐ / ☐☐ / ☐☐☐☐

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

State ☐ Post code ☐

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

- ○ Playing
- ○ Training
- ○ Social game
- ○ Pre-season playing
- ○ Pre-season training
- ○ Officiating
- ○ Other

If other, please provide details

(f) On what surface were you participating?

- ○ Grass
- ○ Synthetic
- ○ Wooden
- ○ Gravel
- ○ Concrete
- ○ 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 conditions at the time of the 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

If other, please provide details

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(j) What activity led to the injury?

- ○ Landing
- ○ Jumping
- ○ Twist / turn
- ○ Side stepping
- ○ Starting
- ○ Stopping
- ○ Running
- ○ Kicking
- ○ Tackle
- ○ Impact by object
- ○ Collision
- ○ Other

If other, please provide details

(k) Was a sports trainer present?

- ○ Yes
- ○ No
- ○ Unknown

2. (a) Injury area: PLEASE SELECT

(b) Injury type: PLEASE SELECT

(c) Injury side: PLEASE SELECT

If other, please specify

(b) Did you suffer from concussion?

- ○ Yes
- ○ No

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

(d) Is treatment complete for this injury?

- ○ Yes
- ○ No

Were you taken to hospital by ambulance?

- ○ Yes
- ○ No

Were you admitted to hospital?

- ○ Yes
- ○ No

If 'yes', dates From ___ / ___ / ___ To ___ / ___ / ___

Name of hospital

Address of hospital

State: Post code:

Status.

- ○ In Patient
- ○ Out Patient

Name of attending doctor

3. 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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SPORTING ACCIDENT CLAIM FORM

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

If 'yes', please give details:

Fund name

Member number

Injury sustained

6. (a) Are you a member of a private health fund? ○ Yes ○ No

If 'yes', please give details. Fund name

Member number

(b) Are you entitled to claim for any of the following benefits?

☐ Private hospital ☐ Physiotherapy ☐ Dental
☐ Chiropractic ☐ Ambulance ☐ Massage
☐ Other ancillary procedures. Please give details below:

6. Are you making, or are you entitled to make, a claim in respect of this injury for any of the following?

☐ Sick leave ☐ Workers compensation
☐ Motor government benefits ☐ Centrelink sickness
☐ Income protection ☐ Superannuation life insurance

If 'yes', please give details

PLEASE NOTE:

Copies of 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 REMEMBER TO INFORM US IN WRITING WHEN YOUR TREATMENT IS COMPLETE.

This will also reduce delays in settlement of your claim.

PART 3: SETTLEMENT DETAILS

NOTE: Once your claim has been settled, we will transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no cheque clearance days. 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

Account number

PART 4: DECLARATION AND AUTHORISATION BY INJURED PERSON

First Name

Surname

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.

Date / /

Signature

WARNING : PERSONS FOUND TO HAVE LODGED A FRAUDULENT CLAIM ARE LIABLE FOR PROSECUTION

PART 5: WITNESS STATEMENT

NOTE: THIS SECTION MUST BE COMPLETED BY AN INDEPENDENT PERSON WHO IS OF NO RELATION TO YOU AND WHO WITNESSED YOUR ACCIDENT.

First Name	
Surname	
Relationship to claimant	
Address	
	State Post code
Telephone *(AH)*	
Telephone *(BH)*	
Date of incident	/ /
Please give a full description of the accident giving rise to the claimant's injury, as you saw it	
Date	/ /
Name of witness	
Signature of witness	

PART 6: 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, unless specified otherwise in the policy schedule.
- The Claimant must be continuously and be totally disabled for more then the excess period noted in the Policy

Employer's name

Employer's address

State Post code

Telephone *(AH)*

Telephone *(BH)*

1. At the time of the accident were you:
   - ○ Full-time employee
   - ○ Part-time employee working ____ hours per week
   - ○ Self-employed on a full-time basis
2. Period of employment — From ____ / ____ / ____ To ____ / ____ / ____
3. What is your occupation/position?
4. What are your gross earnings per annum from this employer?
5. When did you cease work as a result of your injury?
6. 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		@		=	0
(b) Other insurance benefits including personal accident policies		@		=	0
(c) Centrelink		@		=	0
(d) Other salary, wages, income or pay of any nature whatsoever		@		=	0
(e) If other sources, please identify briefly					

7. What was your income for all sources in the twelve months period prior to your accident?

TOTAL ENTITLEMENTS = 0

TOTAL ANNUAL INCOME FROM ALL SOURCES =

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

CURRENT EMPLOYER:

Contact

Address

State Post code

Telephone *(AH)*

Telephone *(BH)*

Period of employment From / / To / /

Occupation / position

Gross annual earnings

FORMER EMPLOYER:

Contact

Address

State Post code

Telephone *(AH)*

Telephone *(BH)*

Period of employment From / / To / /

Occupation / position

Gross annual earnings

PART 6b: EMPLOYER'S STATEMENT

NOTE: TO BE COMPLETED BY CLAIMANTS CURRENT EMPLOYER

I, (Name)

(Position)

Of (Name of company)

At (Address of company)

State: Post code:

Confirm that (Name of employee)

Has been employed continuously

by this firm in the position of (Job title)

Since (Date) / /

His / Her gross annual earnings ($ Amount)

As at (Date of injury) / /

The claimant was entitled to (Number of days) Sick days pay.

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:

Date / /

Signature of person completing section 6b

PART 6C: ACCOUNTANT'S STATEMENT

NOTE: TO BE COMPLETED BY CLAIMANT'S ACCOUNTANT FOR SELF-EMPLOYED PERSONS ONLY

I, (Name)

(Position)

Of (Name of company)

At (Address of company)

State Post code

Confirm that our firm acts as accountant for (Name of claimant)

At

State Post code

And that his/her gross annual earnings (before tax but after expenses) for the 12 month period ended (Date) / /

Amounted to ($ Amount)

His/Her gross annual 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

Income protection? ○ Yes ○ No

If 'yes', name of company

Date / /

Signature of person completing section 6c

PART 7: INCIDENT REPORT

OFFICIAL REPORT

BEFORE YOU COMMENCE FILLING IN THIS FORM:

These questions must be completed by an authorised office bearer of the insured Club / Association (e.g. President, Treasurer, Secretary).
The Team sheet or Injury Report is a separate document.

Claimant's name

Date of injury / /

1. Name of Association

Name of Club

2. Was the above mentioned player registered at the time of the accident? ○ Yes ○ No

3. (a) Were you a witness to the accident described? ○ Yes ○ No

If 'yes', please give details

(b) 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 not, please provide details which outline your concern

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:

(The claimant)

First name

Surname

Position

Email

Telephone *(BH)*

Policy number

Date / /

Signature of authorised office bearer

PART 8: PHYSICIAN'S STATEMENT

ATTENDING PHYSICIAN'S STATEMENT

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 claimant is responsible for the completion of this form without expense to the company

PATIENTS DETAILS:

Claimant's name

Claimant's address

State Post code

Date of injury / /

Telephone *(AH)*

Telephone *(BH)*

What is disabling the patient?
(please give a complete diagnosis)

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

4. (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. Patients occupation _____

2. When was the patient obliged to cease work? ___ / ___ / _____

3. When did, or when will the patient approximately resume?

(a) Some duties ___ / ___ / _____

(b) Full duties ___ / ___ / _____

TREATMENT OF PRESENT DISABILITY:

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

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 ☐

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 the names and addresses of other treating physicians

Name

Address

State Post code

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 of loss of function

PHYSICIAN'S DETAILS:

Full name

Qualifications

Address

State Post code

Telephone *(AH)*

Email

Website

Date ☐☐ / ☐☐ / ☐☐☐☐

Name of medical practitioner

Signature of medical practitioner

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.

- [ ] Sent my Sportscover Claim Form back within 120 days of my injury to:

claims@sportscover.com

OR

Claims Department
Sportscover Australia PTY LTD
Locked bag 6003
Wheelers Hill, VICTORIA 3150

The following requirements are to be returned within 12 calendar months from the date of injury:

- [ ] Receipts and/or statements from Private Health Insurance
- [ ] Physician's statement
- [ ] Notification to Sportscover in writing when all my treatment is complete
- [ ] Team sheet or scorecard

If claiming for loss of income:

- [ ] Employment Declaration form completed by Employer and sent to Sportscover within 120 days of my injury.

PRIVACY AND INSURANCE AT SPORTSCOVER AUSTRALIA

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.

PRIVACY AND INSURANCE AT SPORTSCOVER AUSTRALIA

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