# Australian Rugby Union

# Sporting Accident Report Form

**SLE Worldwide Australia Pty Ltd**

ABN 15 066 698 575 Licence No: 237268

**PO Box H308, Australia Square NSW 1215**

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www.sleworldwide.com.au

Please forward this form to SLE Worldwide Australia Pty Ltd as soon as you have completed the details, within 30 days of injury, even before you have all accounts/ receipts. We may only be able to action your claim if you have completed the Sporting Accident Report Form on *Page 5* and:

- ✓ You have signed and dated the Disclosure Statement and Privacy Consent statement on *Page 3*;
- ✓ You and your Employer have completed the relevant Employment Declaration on Page 6 with proof of income;
- ✓ Your treating Medical Practitioner or Dentist has completed the Medical Practitioner's Statement on *Page 8*
- ✓ Your Club Secretary has fully completed their Declaration on *Page 7*;
- ✓ You have forwarded all receipts, accounts and referrals for treatment via post, fax or email. Should we require the originals, we will notify you in writing.

# Important information please read

## Important note regarding claims for medical expenses

SLE does not provide cover for any account that Medicare covers either in part or full. The Health Insurance Act 1973 (Cth), the Private Health Insurance Act 2007 (Cth) and the National Health Act 1953 (Cth) prohibits SLE from covering expenses claimable from Medicare, or any Medicare Gap. Please do not send any statements, accounts or receipts that relate to Medicare cover.

We do provide cover for Non-Medicare Medical Expenses. We will pay the percentage amount shown in the policy Schedule for expenses relating to private hospital, dental (sound and natural teeth), ambulance, chiropractic, physiotherapy, or any similar registered provider of medical/allied health services, provided a legally qualified Medical Practitioner has certified that the treatment was necessary.

## How to claim Non-Medicare medical expenses

Please note Non-Medicare Medical Expenses are limited for 12 calendar months from date of injury.

When claiming Non-Medicare Medical Expenses you must:

1. Fully complete the Sporting Accident report form;
2. Obtain a referral from your treating Medical Practitioner or Dentist to certify that any medical treatment is necessary. Referrals must be obtained before undergoing treatment.
3. Have your treating Medical Practitioner or Dentist complete the Medical Practitioner Statement (without expense to the Insurer) prior to submitting a claim; and
4. Send all receipts, accounts and referrals for the treatment you are claiming.

## How to claim Loss of Income

The policy has deferral periods for which you will not be reimbursed for each and every claim:

- Excess - 28 days, so you will not be paid for the first 4 weeks off work;

When claiming for Loss of Income you must:

1. Fully complete the Sporting Accident Report Form;
2. Have your treating Medical Practitioner or Dentist complete the Medical Practitioner Statement (without expense to the Insurer) prior to submitting a claim;
3. At least every four weeks forward medical certificates for all periods off work. We do not accept back dated certificates.
4. If you are a wage or salary earner, have your employer complete the Employment Declaration, or
5. If you are self-employed, attach proof of earnings such as your most recent tax return or BAS Statement.

If your disability is continuing, please forward medical certificates every four weeks. Loss of income benefits will not be paid until all statements and documents are submitted.

## Please remember

- If you have private health insurance, you must submit your receipts and accounts to your health fund prior to submitting your claim to us.
- Attach all receipts/accounts for the treatment you are claiming;
- Excesses and percentages of cover under the policy Schedule;
- Please check with your club or phone us on 1800 002 676 for details of exact cover.

## Disclosure Statement & Privacy Consent

SLE Worldwide Australia Pty Limited (**SLE**) is committed to protecting the privacy of the personal information you provide to us. We will use the personal information requested on this form to enable us to consider your claim. We may also need to collect additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if we investigate your claim.

If you do not provide us with this information, we may not be able to process your claim.

We may disclose your personal information we collect on this form and any other additional information we collect in relation to this claim:

- to our relevant staff and contractors involved in delivering our services;
- if a broker collects the claim form from you, to that broker (this is applicable to the claim form only);
- to your employer;
- to your sports association to confirm your eligibility to claim under a policy arranged by it;
- to the insurer, underwritten for certain underwriters at Lloyds of London by their agent SLE Worldwide Australia Pty Limited;
- to reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- to facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- to consultant doctors and physicians (in connection with the handling of your claim);
- to claims investigators and surveillance officers (in circumstances where the claim is investigated by us);
- if required to do so by a law enforcement body or by law; and

You may request access to your personal information we hold about you and where necessary correct any errors in this information (some restrictions and costs may apply).

By completing and returning this form to us, and agreeing to us collecting additional information from the parties specified above in connection with your claim, you agree to us using and disclosing your information as set out above. This consent to the use and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice.

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold about you is accurate, complete and up-to-date.

I agree that a photocopy of this document shall be considered as effective and valid as the original and specifically authorise its use as such.

**Claimant's Name *(please print)*** _____

**Please select one and complete ***one only*:**

□ **I am 18 years of age or older:**

**Claimant's Signature** _____ **Date** ____/____/____

□ **I am 17 years of age or younger:**

**Parent/Guardian Name *(please print)*** _____

**Parent/Guardian Signature** _____ **Date** ____/____/____

# Sporting Accident Report Form

## Questions 1 to 12 refer to your personal details

1. Claimant's Full Name _____
2. Date of Birth ____/____/____
3. Mobile Phone _____
4. Office Hours Phone _____
5. Home Email Address _____
6. Street Number and Address _____
7. Suburb _____
8. State _____
9. Postcode _____
10. Gender □ Male □ Female
11. ARU Registration No. _____
12. Do you hold Private Health Insurance?

    □ No □ Yes:

    Name of Private Health Insurer _____

    Private Health Member Number _____

    What is your Level of Private Health Insurance Cover? (Please select **one *only***)

    □ Hospital only □ Extras only □ Hospital & Extras □ Ambulance Cover

## Questions 13 to 20 refer to your activities at the time of the injury

13. On what date were you injured? ____/____/____
14. What is the name of the venue where you were injured?_____
15. In what organised event were you involved? *(Please select **one box only**)*

    □ Training/Practice session □ Playing a match

    □ Other _____
16. In what Age Grade do you play? *(Please select **one box only**)*

    □ Senior □ Colts □ Junior, Under _____ Years
17. What was your role? *(Please select **one box only**)*

    □ Prop □ Hooker □ Second Row □ Flanker/No 8

    □ Halfback/Five Eighth □ Centre □ Wing/Fullback

    □ Referee □ Coach/Trainer

    □ Club Administrator □ Volunteer □ Spectator
18. Please explain in detail exactly how the injury occurred: _____

    _____

    _____

    _____

19. What were you doing when the injury occurred? (Please select ***one box only***)

□ Being Tackled □ Tackling □ Scrum □ Lineout □ Ruck/Maul

□ Non-Contact

□ Coaching □ Refereeing □ Administrating/Volunteering □ Spectating

20. Were you employed when the injury occurred?

□ No □ Yes

## Financial Institution Account Details

21. I authorise SLE Worldwide Australia Pty Ltd to credit any monies payable to me under the Policy of Insurance to the following account:

Name of Financial Institution _____

Account Name _____

BSB Number _____

Account Number _____

## Employment Declaration for Loss of Income Claim

**You are to complete this section <u>only</u> if you are claiming Loss of Income Benefits**

22. What is your current employment status? *(Please select **one box only**)*

□ Self-employed ***(To be completed by you the Claimant)***

Please provide details for your Accountant below and attach proof of your earnings (Tax Return or BAS Statement), net of business expenses but before income tax and personal deductions, for the 12 months **immediately** preceding this injury.

Name of Accountant: _____

Address: _____

_____

Phone No: _____

□ Employed as a wage earner ***(To be completed by your Manager or Payroll Officer)***

I hereby certify that (Claimant name)_____

- Was employed as _____ (*occupation*)
- With the usual duties of _____ (duties)
- Was injured due to participation in rugby union on _____/_____/_____
- Has been unable to attend their usual occupation from _____/_____/_____ ***AND***
    - Returned to work on _____/_____/_____ ***OR***
    - Is unfit for work and is anticipated to return to:
        - Full duties on _____/_____/_____ ***OR***
        - Partial duties on_____/_____/_____
- Has been employed since _____/_____/_____
- Was employed on the following basis (*Please select **one box only***)

    □ Full-time □ Part-time □ Casual □ Contract
- With an average gross weekly income for the 12 months **immediately** preceding this injury (**excluding** commission, bonus, overtime or other allowances) per week of $_ _____

Name of Manager/Payroll Officer _____

Signature of Manager/Payroll Officer _____

Date _____/_____/_____

Address: _____

_____

Phone Number _____

## Claimant Declaration

**I declare and warrant that the above particulars are true and correct in every detail.**

**I shall notify SLE Worldwide Australia Pty Ltd in writing immediately if any of the above details change.**

Claimant's Name ***(please print)*** _____

Claimant's Signature _____ Date ____/____/____

***Your Club Secretary or Treasurer is to complete the following section.***

## Club Secretary/Treasurer Declaration and Details

I hereby declare that _____ ***(Claimant's name)***

was injured as stated while playing with _____ ***(Club & Grade name)***

on ____/____/____ ***(Date)***

Has the Claimant returned to either training or playing?

□ No, we will advise SLE as soon as the player returns to training playing.

□ Yes, on ____/____/____ ***(Date)***

Did a Medical Practitioner provide a certificate of clearance to return to play?

□ Yes □ No

**Club Secretary Name**_____ ***(please print Name)***

Home Address _____

_____

Office Hours Phone _____

**Club Secretary Signature** _____ Date ____/____/____

## Medical Practitioner's Statement

**The *Medical Practitioner's Statement* must be completed by a qualified medical practitioner only such as a Doctor, Surgeon or Physician, not a health professional such as a physiotherapist, chiropractor etc.**

**The insured is responsible for completion of this form without expense to SLE**

1. Name of Patient _____
2. Address _____
3. Date of Birth ____/____/____
4. Occupation _____
5. Gender □ Male □ Female
6. Are you the regular treating practitioner of this patient?
   □ Yes, I have treated this patient since _____ *(year)*
   □ No, the name and address of the regular treating practitioner that the patient is:

   _____

   _____
7. Please provide a complete diagnosis of the condition: _____

   _____

   _____
8. On what date did a medical practitioner initially treat the patient? ____/____/____
9. On what date did the patient consult you for this condition:
   a. Initially? ____/____/____
   b. Most recently? ____/____/____
10. On how many occasions has the patient consulted you for this condition? _____ *(no. of consults)*
11. Was the patient admitted to hospital?
    □ No □ Yes:
    From ____/____/____ to ____/____/____
    Name and address of hospital _____

    _____

    _____

    Was surgery performed?
    □ No □ Yes, _____*(procedure)*
12. Is future surgery contemplated?
    □ No □ Yes, _____*(procedures)*
13. Has the patient undergone diagnostic tests for this condition?
    □ No □ Yes, please attach the results of the diagnostic tests.

14. What is the nature of the condition?

□ New □ Aggravation of Existing □ Recurrence of Previous

15. Are the patient's description of the symptoms and circumstances of the condition consistent with the results of diagnostic tests or the clinical signs of your diagnosis?

□ Yes □ No, please detail _____

16. Has the patient been unable to work due to this condition?

□ No □ Yes, from _____/_____/_____ ***AND:***

□ The patient returned to work on _____/_____/_____ ***OR***

□ The patient is unfit for work and is anticipated to be able to resume (compulsory):

Partial duties on _____/_____/_____

Full duties on _____/_____/_____

17. Does the patient have any co-morbidity that will affect recovery from this condition?

□ No □ Yes, _____

18. Is the condition likely to cause any permanent disability for this patient

□ No □ Yes:

Type of Disability_____

Percentage Loss of Function _____(%)

19. Do you have any further information that may assist us to assess the condition of the patient?

□ No □ Yes, _____

_____

Signature: _____Date: _____/____/__

Name *(please print):* _____

Qualifications: _____

Address _____

_____

Phone No: _____

Medical Practitioner's Stamp