Golf Australia Sporting Accident

Sportscover Australia Pty Ltd
A.C.N. 006 637 903
A.B.N. 43 006 637 903
AFS Licence No. 230914

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 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 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 all original receipts for Non Medicate Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your 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.

If you have any queries, please call us immediately.

CLAIMS HOTLINE: 1300 134 956

Please send all claims correspondence to:

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

Golf Australia Sporting Accident

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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 Club _____

Name of Claimant _____ _____
Surname *Given Names*

Address for Correspondence _____

_____ State _____ Postcode _____

Telephone (AH) _____ Telephone (BH) _____

Email _____ Fax _____

Date of Birth ___/___/_____ Sex **Male** **Female**

Occupation _____

PART 2 – INCIDENT/INJURY DETAILS

1. (a) Please give a full description of the circumstances of the accident which lead to the injury. _____

_____

_____

_____

(b) When did the injury occur? Date ___/___/_____ Time _____ am / pm

(c) Please provide the address of where the injury occurred _____

_____ State _____ Postcode _____

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.)*

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

*If **yes**,* Name of Hospital _____

PART 2 – INCIDENT/INJURY DETAILS – continued...

Address of Hospital _____

_____ State _____ Postcode _____

In Patient **Out Patient** Name of Attending Doctor _____
(please select one)

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 Fund? **Yes** **No**

*If **yes**, please give details.* Fund Name _____ Member Number _____

(b) Are you entitled to claim for any of the following benefits? **Yes** **No**

☐ Private Hospital ☐ Physiotherapy ☐ Dental ☐ Chiropractic ☐ Ambulance ☐ Massage

☐ Other ancillary procedures. Please give details: _____

7. Are you making, or are you 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**

*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 3 – Settlement Details

NOTE: Once your claim has been settled, we can, if you wish, 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.

☐ 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 4 – 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 5 – WITNESS STATEMENT

We require a statement from anyone who witnessed your accident. Please have that person complete this section.

(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 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.
- The Claimant must be continuously and totally disabled for more then the excess period noted in the Policy.

Employer's Name _____

Employer's Address _____

_____ State _____ Postcode _____

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

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 6 – 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) **Current Employer** _____

Contact _____ Telephone (BH) _____

Address _____

_____ State _____ Postcode _____

Occupation / Position _____

Period of Employment ___/___/___ to ___/___/___

(b) **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 6b – EMPLOYER'S STATEMENT

To be completed by Claimant's current Employer

I _____ **Manager** **Accountant** **Director** **Partner**
please select title

of _____
(Name of Company)

at _____ State _____ Postcode _____

confirm that _____ has been employed continuously by

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 / /

Witness Date / /

PART 6c – ACCOUNTANT'S STATEMENT

To be completed by Claimant's Accountant – For Self Employed Person's Only

I _____ **Manager** **Accountant** **Director** **Partner**
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 ended ____/____/____
(Date of Injury)

amounted to $ _____ .

Income protection **Yes** **No** *If **yes**, name of company* _____

Signature Date / /

Witness 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 Teamsheet or Injury Report is a separate document.

PART 7 – 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? _____

_____

If not, please provide details which outline your concern _____

_____

_____

PART 8 – 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 _____ Telephone ( ) _____

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Attending Physician's Statement

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 without expense to the company.

PART 9 – PHYSICIAN'S STATEMENT

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 injury ____/____/____
2. What were the circumstances surrounding the injury?

   _____

PART 9 – PHYSICIAN'S STATEMENT – Continued.

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? _____
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 / /

PART 9 – PHYSICIAN'S STATEMENT – Continued.

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 _____

Degree _____

Street Address _____

_____ State _____ Postcode _____

Telephone _____ Email _____

Website _____

Signature _____ Date / /

GENERAL COMMENTS (Please provide additional information if required).

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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.

☑ EG. I have received a claim form.

☐ Sent my Sportscover Claim Form back within 120 days of my injury to:

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

☐ Obtained a Doctors Referral

☐ Notified Sportscover in writing when all my treatment is complete

If claiming for Loss of Income

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

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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.

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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