



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 Medicare 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 is a \$20 Excess 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, please contact your Club or Association.

If you have any queries, please call us immediately.

CLAIMS DEPARTMENT
SPORTSCOVER AUSTRALIA PTY.LTD. A.C.N. 006 637 903

CLAIMS HOTLINE: (03) 9721 4747

<p>HEAD OFFICE: 52-62 Stud Road, Bayswater 3153 Suite 1, Level 2/68 Macquarie Street, Parramatta, 2150 Suite 8/27 Mayneview Street, Milton, 4064 PO Box 878 South Perth 6951</p> <p>NEW ZEALAND: Level 6/90 Symonds Street, Auckland, NZ</p> <p>UNITED KINGDOM: Level 3, 141/2 Fenchurch St London, EC3M 6BL</p> <p>INTERNET EMAIL: info@sportscover.com</p> <p>INTERNET SITE: www.sportscover.com</p>	<p>Tel: (03) 9721 4700 Tel: (02) 9689 2311 Tel: (07) 3876 3530 Tel: (08) 9474 0651 Tel: 0800 726 837 Tel: 0207 623 4979</p>	<p>Fax: (03) 9721 4711 Fax: (02) 9689 2470 Fax: (07) 3876 3532 Fax: (08) 9474 0624 Fax: 0800 726 832 Fax: 0207 623 4989</p>	<p>Int: 61 3 9721 4700 Int: 61 2 9689 2311 Int: 61 7 3876 3530 Int: 61 8 9474 0651 Int: 64 9 358 8102 Int: 44 0207 623 3979</p>
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SPORTING ACCIDENT CLAIM FORM

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 relevant to your claim. If you have any questions at all about its contents or meaning, please contact your nearest Sportscover Office.

SPORT :

Name of Claimant.....
Surname *Given Names*

Address for Correspondence.....
..... State Post Code

Telephone (AH) (BH) FAX

Internet Email

Internet Site

Team/Club Association (*in full*)

Date of Birth/...../..... SEX: Male (.....) Female (.....)

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/...../..... Timeam/pm

(d) Where did the injury occur?

2. (a) What injuries did you receive?

(b) When did you first consult a doctor for this injury?

(c) Is treatment complete for this injury? Yes (.....) No (.....)
(If not, please notify us in writing as soon as it is.)

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, Infirmary 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. Are you a member of a Private Health Insurance Fund?

Yes (.....) No (.....)

If yes, please give details Fund Name Member Number

7. 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 (.....)

If yes, please give details

NOTE: Original receipts and all statements of any benefit received from any other source must be sent to Sportscover ASAP. 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.

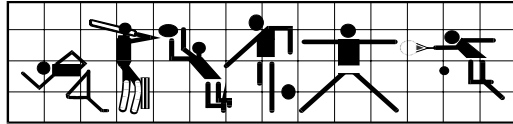
NOTE: Once your claim has been settled, we can, if you wish, transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no cheque clearance delays. If you wish to avail yourself of this service, please provide us with the following details of your bank account.

BANK NAME

BENEFICIARY NAME

BSB NUMBER [] [] [] [] [] [] minimum 6 digits

ACCOUNT NUMBER [] [] [] [] [] [] [] [] [] maximum 9 digits



SPORTSCOVER
QUALITY INSURANCE AT A SPORTING PRICE

A.C.N. 006 637 903
A.B.N. 43 006 637 903

Office Use Only:
Claim No:

OFFICIAL REPORT

(These questions must be completed by an authorised office bearer of the insured club/association)

(Please ensure that all questions have been fully answered)

CLAIMANT'S NAME: _____

DATE OF INJURY: ___ / ___ / ___

1. Name of Association.....Club.....
Team grade player was playing in at the time of accident.
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

.....
.....

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.....
.....
.....

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).

Signed..... Print Name.....

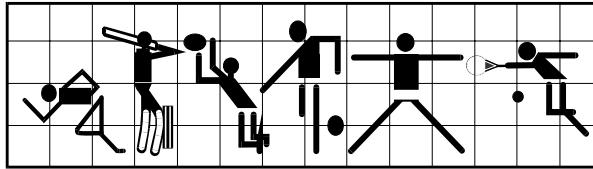
Position.....

Address..... Tel: ().....

SPORTSCOVER AUSTRALIA
 52-62 STUD ROAD
 BAYSWATER VIC 3153
 PH: (03) 9721 4700
 FAX: (03) 9721 4711

Internet Email: info@sportscover.com
 Internet Site: http://www.sportscover.com

CLAIMS



SPORTSCOVER

A.C.N. 006 637 903
 A.B.N. 43 006 637 903

Office Use Only:

Claim No:

SECTION 5 DETAILS OF EMPLOYMENT

(To be completed only if you intend to claim for the Lump Sum Net Loss of Income benefit)

NOTE:

1. A claim cannot be made unless the claimant was gain fully employed and working at least 20 hours a week at the date of injury.
2. The Claimant must be continuously and totally disabled for more than the excess period noted in the Policy.
3. The initial week of disablement is not covered.

At the time of the accident were you - (please circle as appropriate)

* A full - time
employee?

* Part - time employee
working hours/week?

* Self - employed on a
full - time basis?

Name Address

..... State Post Code

a) Please give details of your entitlement (if any) to any of the following benefits:

	No. of weeks	Weekly Amount	Total Entitlement
(i) Sick-pay from your employer	@	=	
(ii) Other insurance benefits including Personal Accident Policies	@	=	
(iii) Other salary, wages, income or pay of any nature whatsoever being	@	=	
	TOTAL	=	

What was your income from all sources in the twelve months period prior to your accident?

Total Annual Income from all Sources - \$

Name and address of your employer or employers during the twelve month period prior to your accident.
 (Please show full names and address - no abbreviations)

Current Employer Contact

Address

Period of employment to Phone No

Former Employer Contact

Address

Period of employment to Phone No

(Please list any additional former employers on a separate list. Leave blank if not applicable.)

EMPLOYER'S STATEMENT

To be completed by Claimants current Employer

I MANAGER/ACCOUNTANT/DIRECTOR/PARTNER

ofof confirm that
(Name of Firm) (Address)

..... has been employed continuously by this firm
since

..... 19

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 19, 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:

.....
.....
.....

Signed Witness

ACCOUNTANTS STATEMENT - Self employed persons only.

To be completed by the Claimant's Accountant

I MANAGER/ACCOUNTANT/DIRECTOR/PARTNER

of of confirm
that (Name of Firm) (Address)

our firm act as Accountants for of
(The Claimant)

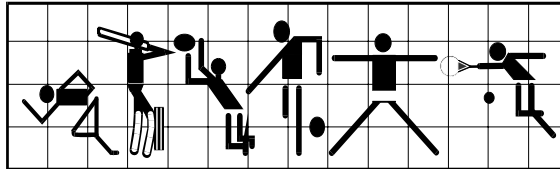
..... and
that his/her gross earnings (before tax but after expenses) for the 12 months period ended / /

..... (Date of Injury)
amounted to \$ Income Protection Yes No Name of
Company.....

SIGNATURE WITNESS

ATTENDING PHYSICIAN'S STATEMENT

To be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor



SPORTSCOVER

A.C.N 006 637 903
A.B.N. 43 006 637 903

**CLAIMS HOTLINE
(03) 9721 4747**

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Office Use Only
CLAIM NUMBER

PATIENT'S NAME AND ADDRESS.....
.....

WHAT IS DISABLING PATIENT?.....
Please give a complete diagnosis of this condition:
.....

HISTORY:

1. When did patient first receive medical treatment?/...../.....
2. (a) Was there a previous history of this or similar condition? Yes No
(b) If Yes, please state condition and advise when previous treatment was given.....
.....
3. (a) How long have you known the patient?/...../.....
(b) Are you the regular general practitioner? Yes No
If not, please advise who is

IF INJURY:

1. When did patient suffer injury?
2. What were the circumstances surrounding the injury?

IF SICKNESS:

1. When was sickness first contracted?.....
2. When did symptoms become evident?.....

DEGREE OF DISABILITY:

1. Patient's Occupation?.....
2. When was 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
If yes, please advise 1. Name and/ of hospital
.....

2. Period of Confinement From/...../..... To/...../.....

4. Was confinement in a convalescent home necessary after hospitalisation Yes No

If Yes, give details.....

5. What are the current subjective symptoms?

6. Please give results of any objective findings

1. X-Rays

2. Other Tests-Please advise tests done and findings 1.

2.

7. What surgical procedures have been performed

8. What surgical procedures are contemplated

Are there any underlying conditions affecting recovery from the current condition? Yes No

If yes, could you advise nature of underlying conditions and how they affect disability and recovery

Has patient any other physical or mental impairment? Yes No

If yes, please describe.....

Please advise names and addresses of other treating physicians.....

If you have terminated treatment, please advise date/...../.....

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?.....

Is there any permanent disability at present? Yes No

If yes, please explain giving estimated percentage loss of function

DATE:

SIGNATURE:

DEGREE:

Name: (Please Print) _____

Street Address _____

City or Town _____ State _____ Phone No. _____

Internet Email _____ Internet Site _____

SPORTSCOVER PTY. LTD. A.C.N. 006 637 903

HEAD OFFICE:

52-62 Stud Road, Bayswater 3153
Suite 1 Level 2 68 Macquarie St, Parramatta, 2150
Suite 8/27 Mayneview Street, Milton, 4064
P.O. Box 878 South Perth 6951

Tel: (03) 9721 4700
Tel: (02) 9689 2311
Tel: (07) 3876 3530
Tel: (08) 9474 0651
Tel: (09) 358 8102
Tel: 0207 623 4979
INTERNET SITE:

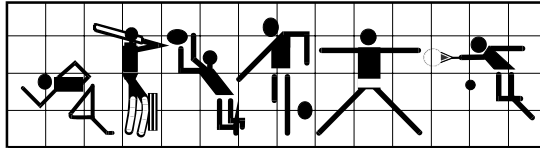
Fax: (03) 9721 4711
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Fax: (08) 9227 2247
Fax: (09) 358 1350
Fax: 0207 623 4989
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Int: 61 2 9689 2311
Int: 61 7 9876 3530
Int: 61 8 9474 0624
Int: 64 9 358 8102
Int: 44 207 623 4979

NEW ZEALAND:

Level 6 90 Symonds Street Auckland
Level 3 141/2 Fenchurch St, London, EC3M 6BL
info@sportscover.com

UNITED KINGDOM:
INTERNET EMAIL:



SPORTSCOVER

A.C.N. 006 637 903

A.B.N. 43 006 637 903

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 (03) 9721 4747.

E.G. I have received a claim form

Sent my Sportscover Claim Form back within 120 days of my injury to **52-62 Stud Road, Bayswater Vic 3153**

THE FOLLOWING REQUIREMENTS ARE TO BE RETURNED WITHIN 12 CALENDAR MONTHS FROM THE DATE OF THE 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

206 Health Insurance Act 1973

Si 126

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

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) 9721 4700
61 3 9721 4700 (International)
Fax: (03) 9721 7711
Email: Privacy@sportscover.com