



# Sporting Accident Claim

Policy Number

Claim Number

### Claiming Notes:

- The issue of this form does not constitute an admission of liability on the part of the insurer.
- Please complete this claim and forward to your Broker within 30 days of injury.
- Do not wait for your accounts before sending claim.
- Continue your treatment and forward ORIGINAL itemised accounts and receipts.
- Claims without referral from a medical practitioner or dentist following injury will be denied.
- Government legislation does not allow us to refund any part of an account which can be claimed in part through Medicare.  
**DO NOT SEND ANY MEDICARE ACCOUNTS.**

## PLAYER DETAILS

Name	Surname		Given Name(s)	
Are you registered for GST?	No <input type="checkbox"/> Yes <input type="checkbox"/>	What is your ABN?	<input type="text"/>	
1. Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", go to question 3			
2. Will you be claiming an amount less than 100%?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Specify amount claimed			%
3. Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", go to Address			
4. Will you be claiming an amount less than 100%?	No <input type="checkbox"/> Yes <input type="checkbox"/> If "Yes", specify amount claimed			%
Address			State	Postcode
Contact Numbers	Home		Work	( )
	Mobile		Email	
Occupation			Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth / /
Sport			Club/Team	
Association/League			Registration No. (if applicable)	

## INJURY DETAILS

Date of Injury	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time of Injury	<input type="text"/> am/pm
Were you:	Playing <input type="checkbox"/>	Training <input type="checkbox"/>	Travelling <input type="checkbox"/>
Type of Injury	<input type="text"/>		
How did injury occur?	Collision <input type="checkbox"/>	Tripped <input type="checkbox"/>	Fell <input type="checkbox"/> Other <input type="checkbox"/> – give details
<input type="text"/>			
Have you suffered this injury or similar injury in the past?	No <input type="checkbox"/> Yes <input type="checkbox"/> – give details		
<input type="text"/>			
Are you entitled to claim under any other personal accident policy or social security for this injury?	No <input type="checkbox"/> Yes <input type="checkbox"/>		

## HEALTH FUND MEMBERSHIP

**If you are a member of a Private Fund, you MUST claim on your fund first. Please forward fund statements with this claim.**

Are you a member of a Private Health fund?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Membership Number	<input type="text"/>
Name of Fund	<input type="text"/>		
Have you elected Extra Cover i.e. Physio/Chiro/Dental?	No <input type="checkbox"/> Yes <input type="checkbox"/>		
Have you elected Hospital and Ambulance Cover?	No <input type="checkbox"/> Yes <input type="checkbox"/>		

## PRIVACY

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website [www.qbe.com](http://www.qbe.com) or contact the Compliance Manager on 02 9375 4656 or email [compliance.manager@qbe.com](mailto:compliance.manager@qbe.com) for further information.

## INJURED PLAYER'S AUTHORISATION AND DECLARATION

I hereby authorise any hospital, physician or other person who has attended me or any employer and the Department of Social Security, to furnish QBE or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatment, copies of all hospital 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.

The information and answers given above are true and complete in every detail.

I understand the claim may be refused or reduced if information is withheld.

I authorise that QBE give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

I have read and understand the information sheet that tells me what I am covered for by this Policy.

Signature of Injured Player

Date  /  /

## DELAYS IN SEEKING MEDICAL ADVICE AND THE IMMEDIATE COMMENCEMENT OF RECOMMENDED TREATMENT COULD PREJUDICE YOUR ENTITLEMENT UNDER THE POLICY

### INCOME AND EMPLOYMENT DETAILS – for Employees

**Must be completed by employer or salary officer. PLEASE SUPPLY A COPY OF YOUR LAST GROUP CERTIFICATE.**

Employer

Address  State  Postcode

Date Commenced with Employer  /  /  Date Ceased Work Due to Injury  /  /

Expected Resumption Date  /  /

Gross Weekly Income Prior to Injury \$

Gross Annual Income \$

Details of Payments During Time off Work (i.e. Holiday/Sick Leave)

  

Paid from  /  /  to  /  /

Salary Officer's Name  Telephone No. (  )

Salary Officer's Signature  Date  /  /

### INCOME AND EMPLOYMENT DETAILS – for Self-Employed persons

You must provide all the details above on a Statutory Declaration and have it signed and witnessed by a Justice of the Peace. You must also advise on the Statutory Declaration whether or not you have any other Personal Accident or Income Protection policy that you can claim on for this injury. If you do, you should advise the name of the Insurer and contact phone number, policy number, sum insured per week or per month, and the waiting period or excess. You must also send a copy of your last Taxation Assessment Notice and Profit/Loss Statement.

### CLUB OFFICIAL'S DECLARATION

This is a legal document and false declaration can result in legal implications for both the individual and the Club.

I,  of   
Club Official Club

certify that

sustained injuries resulting in this claim on  /  /  at  am/pm  
Date Time

whilst training/playing at

Club Mailing Address  Postcode

Is the player a registered player? No  Yes  – Registration No.

Did the player appear on official team playing sheet? No  Yes

Rate: Student  Non Student

Signature  Date  /  /

Telephone Number (Home) (  ) (Business) (  )

## PHYSICIAN'S STATEMENT

**Must be completed by a dentist, doctor or surgeon not by a physiotherapist or chiropractor. Any expense for the completion of this statement can only be met by the patient and not by the Insurer.**

Patient's Name    
Surname Given Name(s)

**CONDITION** – give a complete diagnosis of this condition


### HISTORY

When did the patient first suffer the injury? Date  /  /  Time  am/pm

What did the patient tell you were the circumstances surrounding the injury?


When did the patient first receive medical treatment? Date  /  /  Time  am/pm

When were you first consulted? Date  /  /  Time  am/pm

Was there a previous history of this or a similar condition? No  Yes  – When was treatment given?


Were there any structural deficiencies or weaknesses to this region prior to this injury that directly contributed to this injury? No  Yes

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

If "Yes", advise nature of underlying condition and how it affects disability and recovery:


### DEGREE OF DISABILITY

When was the patient obliged to cease work? Date  /  /  Time  am/pm

If the patient is still disabled, when will the patient be able to resume;

• one or more of the material tasks of their occupation? Date  /  /

• all of the tasks of their occupation? Date  /  /

If the patient has recovered, when was the patient able to resume:

• one or more of the material tasks of their occupation? Date  /  /

• all of the tasks of their occupation? Date  /  /

**A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.**

**PHYSICIAN'S STATEMENT (continued)****REFERRAL (Must be completed for supporting services)**
 Physiotherapy  Chiropractic  Osteopathic  Massage Services  Other 

 Date Referred  /  /  Number of treatments  Number of weeks  Review date for further referral for treatment  /  / 
**HOSPITAL DETAILS**
 Was the patient confined to hospital? No  Yes  – Give details

Name of Hospital	Address	Period of Confinment	
		From	To
		/ /	/ /
		/ /	/ /
		/ /	/ /

**OTHER DETAILS**

What are the current symptoms?

  


Give results of any objective findings:

 X-rays 

 Other Tests – specify 

What surgical procedures have been performed or are being contemplated?

  
  


Advise names and addresses of other treating physicians

Name	Address

 Have you terminated treatment? No  Yes  – On  /  / 

What is the current prognosis?

  
  


 Are there any further remarks which may assist us in assessing this condition? No  Yes  – Give details

  
  


 Doctor's Name  Qualifications 

 Address  State  Postcode 

 Telephone  (  ) 

 Signature  X Date  /  /