THE ATHLETE HUB

RESISTANCE SPORTS SCIENCE

Athlete Injury Report Form

A REQUEST FOR INFORMATION ON SPECIFIC ATHLETE INJURY

Parent or guardian must fill out and sign the form if the athlete is under 17.
(Please return to us as soon as possible.)

FULL NAME:

CONTACT NUMBER: **EMAIL:**

SPORT: **POSITION:**

INJURY DATE: **REFERENCE :**

- [ ] I understand and agree to release this information in regards to my sporting injury to Resistance Sports Science.
- [ ] I have undergone scans for my injury (if so please bring to first appointment).
- [ ] I have spoken to an RSS Coach or Practitioner in regards to my injury.
- [ ] I acknowledge and confirm that Resistance Sports Science will forward my information along with a initial report to my selected insurance provider.

Signature of Parent and/or Nominated Person Above

RESISTANCE SPORTS SCIENCE

Resistance Sports Science
168B South Pine Road Enoggera, QLD 4051
07 3172 2553 / info@resistancess.com

Marsh JLT ATC INSURANCE SOLUTIONS V-INSURANCE GROUP

PERSONAL INJURY CLAIM FORM

Australian Football National Risk Protection Programme

IMPORTANT INFORMATION

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- You are an Insured person – player, umpire, official or volunteer; and
- You have sustained an injury – whilst participating in a sanctioned AFL activity/event; and
- You have incurred costs – Non-Medicare medical costs

Before completing this form, please read the Product Disclosure Statement (PDS) on our website www.marsh.com/au/financial-services-guide.html

WHAT IS COVERED?

Non-Medicare Medical Costs
Death & other Capital Benefits

Loss of Income cover is available as an optional extra that can be purchased for additional premium.

HOW MUCH CAN I CLAIM?

The following table outlines the various levels of cover within this Programme.

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursement	75% Reimbursement	90% Reimbursement	90% Reimbursement
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim

- All clubs receive, at least, the Bronze level of cover at the start of each period of cover.
- Clubs/Leagues may choose to upgrade to a higher level of cover for an additional premium.
- Upgraded cover is valid only from the date of purchase.
- If you do not know what level you have, please contact your club and/or league for details.

HOW TO LODGE A PERSONAL INJURY CLAIM

1. Complete ALL sections of this form
2. Send your completed form to Echelon as soon as possible (and within 270 days from the injury date)
3. Echelon will confirm receipt of your claim and provide you with a claim number
4. Any further costs can be submitted to Echelon quoting this claim number
5. Documents can be submitted by email, post or fax

HOW TO SEND COMPLETED FORMS			
Email:	sportsclaims@echelonaustralia.com.au		
Post:	Echelon Claims Services – GPO Box 1693 Adelaide SA 5001		
Fax:	08 8235 6450	Phone No:	1800 640 009

IMPORTANT INFORMATION

You can't claim for any services where you receive a rebate from Medicare Submit only original receipts with your claim form

We recommend you retain a copy of all receipts and your claim form for your records Claim through your Private Health Fund first, where possible.

WHO IS ECHELON?

Echelon Australia Pty Ltd (Echelon) is a business of Marsh & McLennan Companies (MMC). Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the AFL National Risk Protection Programme.

WHO IS MARSH?

Marsh is the appointed broker for the AFL National Risk Protection Programme and is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries.

SECTION A - CLAIMANTS DETAILS

Claimant's Name:					
Postal Address:					
Occupation:					
Email Address:			Phone Number:		
Date of Birth:				☐ MALE	☐ FEMALE
Date of Injury:		Time Of Injury:		☐ AM	☐ PM
Club Name:					
Association/League Name:					

Describe your injury and how it happened (please attached additional pages if required):

INJURY RESEARCH DATA					
Session:	☐ Playing		☐ Training		☐ Travelling
	☐ Event		☐ Warmup/down		☐ Other
Injured Person:	☐ Player	☐ Umpire	☐ Official	☐ Trainer	☐ Other
Grade:	☐ Senior	☐ Reserve	☐ Junior	☐ Not Applicable	
Surface Conditions:	☐ Wet		☐ Dry		☐ Muddy
	☐ Indoor		☐ Other		
Period:	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ Not Applicable
When will you resume WORK?					
When will you resume TRAINING?					
When will you resume PLAYING?					
Do you have Private Health Insurance?				☐ YES	☐ NO
If YES, what is the name of your Private Health Insurance Provider?					
Private Health Coverage:	☐ Dental	☐ Hospital	☐ Ambulance	☐ Physiotherapy	
Ambulance Membership?				☐ YES	☐ NO

PAYMENT DETAILS			
Bank:		Account Name:	
BSB:		Account Number:	

CLAIMANT DECLARATION

By signing the declaration below, you confirm and agree to the following:

1. The injury was sustained accidentally during a football activity and is not a pre-existing illness or condition.
2. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.marsh.com/au/financial-services-guide.html
3. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).
4. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of MARSH, the insurer, the Trustee and the Claims Managers.
5. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish MARSH's representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.
6. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.
7. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.
8. You authorise any and all information regarding claims with any other insurer to be released to MARSH's representatives.

Claimant's Signature: (*Parent or Guardian if under 18 years*)		Date:	

SECTION B CLUB DETAILS				
Claimant's Full Name:				
Club Name:				
Club Contact:				
Position within Club:				
Email Address:		Phone Number:		

INJURY DETAILS				
League/Association Name:				
Registration Details:			☐ YES	☐ NO
Non-Medicare Cover: (If Known) What Cover Level has the Club purchased for this Period of Cover? (Optional – if unsure please leave blank)	☐ Bronze (50%)	☐ Silver (75%)	☐ Gold (90%)	☐ Platinum (90%)
Loss of Income Cover: (If Known) Has the club purchased Loss of Income this year? If YES what is the weekly limit purchased by the Club if known?	☐ YES	☐ NO	$_____ Per Week	

Date of Injury:		Time of Injury:		☐ AM	☐ PM
Circumstances:	☐ Playing	☐ Training	☐ Travelling	☐ Other (Please Specify)	
Opposition Club Name: (If Applicable)					
Ground/Location Where the Injury Occurred:					

Has the Claimant returned to TRAINING?	☐ YES	☐ NO
If YES, date Claimant returned?		
Has the Claimant returned to COMPETITION?	☐ YES	☐ NO
If YES, date Claimant returned?		

CLUB DECLARATION

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or League (as above).

B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.

C. You declare the Claimant's injury was sustained accidentally during the football activity noted above and is not a pre- existing illness or condition.

D. You understand that registering your club with MARSH Sport is a requirement of the AFL National Risk Protection Programme for each Period of Cover.

E. You confirm the club's level of cover as per the details provided above.

Club Representative's Signature:		Date:	

SECTION C – LOSS OF INCOME (TO BE COMPLETED BY THE CLAIMANT)

Do you wish to claim Loss of Income Benefits?	☐ YES	☐ NO

IF YOU ARE NOT CLAIMING LOSS OF INCOME BENEFITS PLEASE DO NOT COMPLETE THIS SECTION. PLEASE PROCEED TO SECTION D

The elimination period is a period of consecutive days during which no benefits are payable. The elimination period under the insurance policy for loss of income benefits is 14 days or your sick leave entitlement as an employee whichever is greater.

Can you claim compensation from any other policy that includes loss of income benefits? (Such as Workers Compensation)	☐ YES	☐ NO
Have you ever made previous claims in respect to a personal accident insurance policy or plan?	☐ YES	☐ NO
Have you engaged in any other income earning employment since you became injured?	☐ YES	☐ NO

TO BE COMPLETED BY THE CLAIMANTS EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)

Claimants Name:				
Employer/Business:				
Contact Person:				
Postal Address:				
Email Address:				
Phone (Bus. Hours):			Mobile:	
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed

Employment Details If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.

Employee's NET weekly salary:	$	
Employee's GROSS week salary:	$	
Date Employee commenced with company:		
Injury Details:		
Date employee ceased work:		
Date expected to resume duties:		
Returned to Work:		
Has the Employee returned to work?	☐ YES	☐ NO
If YES, what date did the Employee return?		
Salary Received:	$	
During the period of incapacity, has the employee received a salary?	☐ YES	☐ NO

If YES, what for?						
Sick Leave:	☐ YES	☐ NO	From:		To:	
Annual Leave:	☐ YES	☐ NO	From:		To:	
Other:	☐ YES	☐ NO	From:		To:	

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived from playing sport.

EMPLOYERS DECLARATION:			
By signing the declaration below, you confirm and agree to the following: A. You are the Claimant's current employer (or accountant if the claimant is self-employed), B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate, C. You will supply upon request any further information as required for the determination of this claim.			
Employer's Signature: * Accountant's signature (if claimant is self-employed)		Date:	

SECTION D - PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH - This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

Claimant's First Name:		Claimant's Last Name:	
Physician's Name:		Phone Number:	

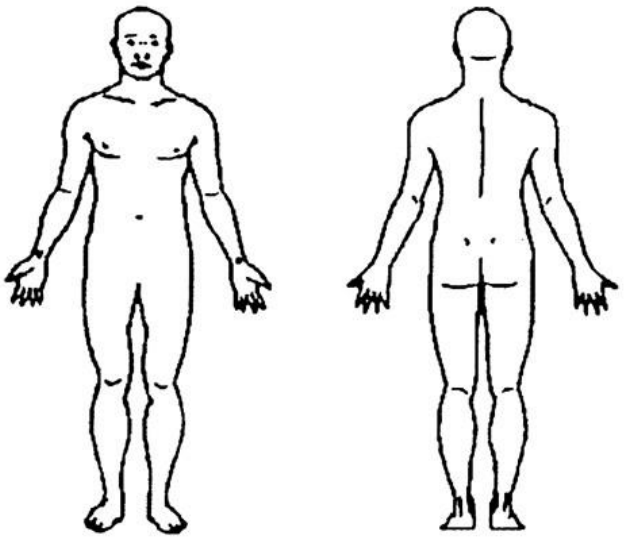
INJURY CONSULTATION

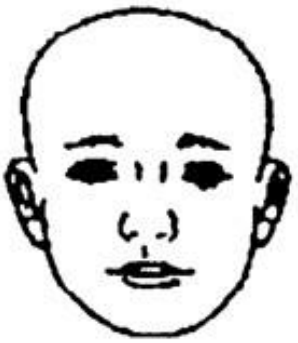
Date of Injury:		Date of Consultation:	

Diagnosis/History of injury:

Injury Location:	☐ Ankle	☐ Arm	☐ Dental	☐ Facial	☐ Foot
	☐ Hand	☐ Head	☐ Internal	☐ Knee	☐ Lower Leg
	☐ Shoulder	☐ Spinal	☐ Torso	☐ Upper Leg	

Please mark (⚑) the anatomical location below:





Injury Type:	☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut	☐ Death
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Rupture	☐ Sprain
	☐ Strain	☐ Fatigue/Debilitation			

First Medical Treatment:	
Name of attending physician:	
Date of treatment:	

Do you consider the Claimant's injury to be a NEW injury?	☐ YES	☐ NO
Do you consider the Claimant's injury to a recurrence of a previous injury?	☐ YES	☐ NO

INJURY CONSULTATION CONTINUED		
If YES, please provide details and a description:		
Does the Claimant have any congenital defects or chronic diseases?	☐ YES	☐ NO
If YES, please provide details and a description (dates, name of treating doctor, etc.):		
Have you referred the patient to any other services or treatment?	☐ YES	☐ NO
If YES, please provide details below:		
Physiotherapy:	☐ YES	☐ NO
If YES, approx. number of treatments required.		
Chiropractic's:	☐ YES	☐ NO
If YES, approx. number of treatments required.		
Surgery:	☐ YES	☐ NO
If YES, please provide details		
Other:	☐ YES	☐ NO
If YES, please provide details		
Has the Claimant been able to do any work since the injury occurred?	☐ YES	☐ NO
What date do you advise the Claimant to return to playing Football?		
Physician's Signature:		
Date:		

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT

I,	examined	on	
(Medical Practitioner's Name)	(Claimant's Name)		(Date of Examination)

In my opinion, this person is/has been unfit to work from _____ To _____

(First day of Incapacity) (Last day of Incapacity)

Please provide any further comments in regard to your assessment of the injury/condition:

By signing the declaration below, you confirm and agree to the following:

You have examined the Claimant's injury as described on this form;

You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature:		Date:	

For more information, please refer to MARSH Sport's web site www.marsh.com/au/afl

DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty of disclosure under the Insurance Contracts Act 1984 (Cth) to tell us anything that you know, or could reasonably be expected to know, may affect the insurer's decision to insure you and on what terms. You have this duty until the contract of insurance is entered into. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

If we ask you questions that are relevant to the insurer's decision to insure you and on what terms, you must tell us anything that you know and that a reasonable person in the circumstances would include in answering the questions. Also, we may give you a copy of anything you have previously told us and ask you to tell us if it has changed. If we do this, you must tell us about any change or tell us that there is no change. If you do not tell us about a change to something you have previously told us, you will be taken to have told us that there is no change.

You do not need to tell us anything that: reduces the risk insured, or is common knowledge, or the insurer knows or should know as an insurer; or the insurer waives your duty to tell them about.

If you do not tell us something:

If you do not tell us anything you are required to, the insurer may cancel your contract or reduce the amount it will pay you if you make a claim, or both. If your failure to tell us is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

If you are in any doubt as to the extent of the duty of disclosure or whether a piece of information ought to be disclosed, just contact your Marsh Client Risk Adviser.

MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Marsh Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Marsh') draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Marsh products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984 (Cth), the Marine Insurance Act 1909 (Cth) or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Marsh's Associated Entities, which are all businesses of Marsh & McLennan group of companies ('MMC').
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other MMC companies, insurers, reinsurers and other third party service providers (e.g. data storage providers) in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act, you must obtain it with the individual's consent.
- We will use and disclose your personal information in accordance with our Privacy Policy. By completing this form you confirm that you have read the Marsh Privacy Policy available on our website (www.marsh.com.au) and you authorise and consent to Marsh collecting, holding, using and disclosing any personal information collected by means of the enclosed document in accordance with the terms of the Marsh Privacy Policy, including for the purposes explained in this collection statement above. If there are any inconsistencies between the terms of this collection statement and the terms of the Marsh Privacy Policy, the terms of the Marsh Privacy Policy prevail to the extent of that inconsistency. You may modify or withdraw your consent at any time. If you do not give us consent or subsequently modify or withdraw your consent, we may not be able to provide you with the products or services you want.
- You can contact our Privacy Officer by:

  Email – privacy.australia@marsh.com
  Phone – (02) 8864 7688
  Post – PO Box H176, Australia Square NSW 1215

V-INSURANCE GROUP

Arch

Office use only

Policy Number: _____

Claim Number: _____

BASEBALL AUSTRALIA

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone (02) 8256 1770 Fax (02) 8256 1775
Email claims@csnet.com.au

V-INSURANCE GROUP

INSURANCE BROKER FOR BASEBALL AUSTRALIA;
Authorised Representative No. 432898 a corporate
authorised representative of Willis Australia Limited AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547

BASEBALL AUSTRALIA
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $100,000 (other than anyone under 18 and over 75 years old $20,000 maximum). The paraplegia and quadriplegia benefit is $250,000 ($20,000 for members aged over 75 years).

Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses up to a maximum of $2,250 ($3,000 for dental) Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance. 100% Ambulance costs reimbursement under this benefit. – Benefit subject to a nil excess for claimants who are covered by private health insurance only claiming ambulance, or otherwise $20. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

Student Assistance Benefit

Reimburses 100% of costs incurred up to a maximum of $400 per week for up to fifty two (52) weeks being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student – 7 day excess.

Home Help Benefit

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of $400 per week for up to fifty two (52) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy – 7 day excess.

Parents Inconvenience Allowance

Pays up to a maximum of $1,500, whilst the child is hospitalised to offset costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age. The maximum benefit period is fifty two (52) weeks and the policy excess is 7 days.

Loss of Income

Cover for 85% of your net weekly income or up to a maximum of $250 per week, whichever is the lesser. The benefit period is fifty two (52) weeks and the excess is 7 days.

Funeral Benefit

If a death benefit has been paid under capital benefits, an amount of $10,000 is available for reimbursement of funeral expenses.

Important Notes

This insurance cover is underwritten by: Arch Underwriting at Lloyd's (Australia) Pty Ltd
ABN 27 139 250 605 AFSL 426746. Level 4,
68 York Street Sydney NSW 2000

1. This summary of cover provides factual information about the Baseball Australia Insurance Program.
2. This summary of cover provides factual information about the Baseball Australia Insurance Program The policy with full conditions is available at www.vinsurancegroup.com/baseball or by contacting Baseball Australia.
3. This insurance program commenced on 30 November 2020 and expires on 30 April 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Baseball Australia who, through injury or accident, incur financial loss and who would not have otherwise received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
5. Baseball Australia are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the Baseball Australia insurance program can be obtained by visiting

http://www.vinsurancegroup.com/baseball

HOW TO MAKE A CLAIM

Dear Baseball Australia (BA) member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

2. Please ensure that you fully complete pages 4, 5 & 6 and sign and date the Declaration.

3. For claims involving Loss of Income:

a) You must complete page 8 and have your employer/salary officer to complete page 8. If self employed, you must have your accountant complete these details;

b) You must complete the Tax File Declaration form on page 9. If you are employed and pay tax on the income you earn (known as PAYE), the ATO requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be forwarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.

c) Have your Attending Physician or Physiotherapist complete the page titled "Doctor's Statement" on pages 11 and 12.

4. For claims involving Non-Medicare medical expenses:

a) Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).

b) Have your Attending Physician complete the "Attending Physician" statement on page 12.

5. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital room and theatre fees, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

6. Once you have completed all sections of the claim form, please have your Club and State Association complete and sign page 4 & 5 confirming that your injury occurred during a sanctioned activity.

7. Once you have completed your claim form, please forward to Corporate Services Network. They handle all claims for the insurer. Their contact details are as follows;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone (02) 8256 1770
Fax (02) 8256 1775
Email claims@csnet.com.au

8. Your reimbursement cheques will be sent to you directly by Corporate Services Network.

9. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

10. If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the V-Insurance Group Team on ph: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Claimant's Given Name:	Surname:		Member No (if applicable):
Name of Association:	Name of Club / League:	Name of team/age group/grade:	
Occupation:	Date of Birth: / /	Gender (please tick): ❑ Male ❑ Female	Email:
Address		State	Postcode
Phone Number (work): ( )	Home ( )	Mobile	

Please tick the category applicable ❑ Player ❑ Official ❑ Coach ❑ Umpire ❑ Other

If Other, please advise _____

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I (insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Corporate Services Network to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Corporate Services Network and their service providers in order to assess the claim. Corporate Services Network complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant _____ Date_____

(or Legal Guardian if under 18 years of age)

DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: ( ) Email:

I, the above mentioned Baseball Australia Club Official, confirm that the claimant was a registered and Financial member of the Baseball Australia Club and confirm that the claimant was taking part in an insured activity as defined by the Personal Accident Insurance with Baseball Australia at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ❑ Yes ❑ No

If yes, please detail _____

_____

Dated: / /	Signature of Club Official:

DECLARATION BY STATE ASSOCIATION

Name of State Association:	Name of State Association Official making this statement:
Official Position:	Telephone Number: ( ) Email:
Address	State Postcode

I, the above mentioned Baseball Australia Official, confirm that the claimant was a registered and Financial member of Baseball Australia and was an insured person as identified in the Personal Accident Insurance with Arch Underwriting at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ❑ Yes ❑ No

If yes, please detail _____

_____

Dated: / /	Signature of State Association Official:

Office use only

Policy Number: _____

Claim Number: _____

ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury?

When did your accident occur?

Date: / / Time: am/pm

Was your activity at the time of the accident? (please tick)	Officially organised competition	❑
	Officially organised training	❑
	Social or private competition	❑
	Travelling to and from activity	❑
	Sanctioned fundraising/social event	❑

Please provide the address of where the injury occurred:

State the name of any one witness to the injury:	Address of witness:
Person to whom accident/incident was reported?	Date and time reported? Date: / / Time: am/pm

Brief summary of treatment/action taken at the time of the accident/incident:

Was hospitalisation required?	If yes, please advise the name of hospital:
If admitted into hospital, how long were you there?	Name of person who gave treatment?
Do you have Private Health Insurance?	If yes, please give fund name:

Advise when you did (or expect to):	Cease work/normal activities _____
	Cease training _____
	Cease participating _____
	Resume work/normal activities _____
	Resume training _____
	Resume participating _____

Have you ever had this injury or similar injuries in the past?	If yes, please advise when: / /

The following information is required for Baseball Australia research to assist with Risk Management. <u>Answering these questions will not affect your claim.</u>		
Surface at point of injury? (please tick)	Grass	❑
	Astroturf / Synthetic Grass	❑
	Other, please advise……	❑
Weather conditions? (please tick)	Fine	❑
	Rain	❑
	Showers	❑
	Extreme Heat	❑
	Extreme Cold	❑
What were you doing when the accident occurred?	Batting	❑
	Fielding	❑
	Catching	❑
	Running Bases	❑
	Warming Up	❑
	Other	❑

LOSS OF INCOME
(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(Please tick the box)	YES	NO
1. Can compensation be claimed under Workers Compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER / SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer: State Postcode	
Date ceased work due to injury: / /	Date expected to resume normal duties: / /
Employee weekly salary as at date of injury: Net $..... Gross $..... If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

❑ Self Employed ❑ Full Time ❑ Part Time ❑ Casual

During the period of incapacity the employee has received

$.....	Normal Pay	From	……/……/……	to	……/……/……
$.....	Sick Pay	From	……/……/……	to	……/……/……
$.....	Workers Compensation	From	……/……/……	to	……/……/……
$.....	Other (please specify)	From	……/……/……	to	……/……/……

Has the employee returned to work? ❑ Yes ❑ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ❑ Yes ❑ No

A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountant's Company Stamp:	Date: / /

Australian Government
Australian Taxation Office

Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
- Print **X** in the appropriate boxes.
- Read all the instructions including the privacy statement before you complete this declaration.

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 3, 3b)

ato.gov.au

Section A: **To be completed by the PAYEE**

1 What is your tax file number (TFN)?

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN. ☐

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax. ☐

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance. ☐

2 What is your name? Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname or family name

First given name

Other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

4 What is your date of birth? Day / Month / Year

5 What is your home address in Australia?

Suburb/town/locality

State/territory Postcode

6 On what basis are you paid? (Select only one.)

Full-time employment ☐ Part-time employment ☐ Labour hire ☐ Superannuation or annuity income stream ☐ Casual employment ☐

7 Are you an Australian resident for tax purposes? (Visit **ato.gov.au/residency** to check) Yes ☐ No ☐

8 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Yes ☐ No ☐ Answer **no** here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions. No ☐

10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093). No ☐

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

(b) Do you have a Financial Supplement de

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

DECLARATION by payee: *I declare that the information I have given is true and correct.*

Signature — You MUST SIGN here

Date: Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Once section A is completed and signed, give it to your payer to complete section B.

Section B: **To be completed by the PAYER** (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number?

30 074 864 609

Branch number (if applicable) 004

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes ☐ No ☐

3 What is your legal name or registered business name (or your individual name if not in business)?

CORPORATE SERVICES

4 What is your business address?

Suburb/town/locality: SYDNEY

State/territory Postcode

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 0282561770

6 If you no longer make payments to this payee, print X in this box. ☐

DECLARATION by payer: *I declare that the information I have given is true and correct.*

Signature of payer

Date: Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Return the completed original ATO copy to:
Australian Taxation Office
PO Box 9004
PENRITH NSW 2740

IMPORTANT
See next page for:
- payer obligations
- lodging online.

Sensitive (when completed)

30920716

NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap).

Are you a member of an Ambulance Service? ❑ Yes ❑ No

Are you a member of a Private Health Fund? ❑ Yes ❑ No

If yes, please provide details .....

Hospital Cover? ❑ Yes ❑ No

Extra's covering, Physio etc ❑ Yes ❑ No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
				Total	
				Less Excess	
				TOTAL AMOUNT OF CLAIM	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor:.....

Address:.....

V-INSURANCE GROUP

Office use only
Policy Number:.....
Claim Number: .....

AR No. 432898 Willis Australia Limited AFSL: 240600
Phone (02) 8599 8660 or local call cost only 1300 945 547
Completed claim forms should be sent to
Corporate Services Network, GPO Box 4276 Sydney NSW 2001
or via email claims@csnet.com.au

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

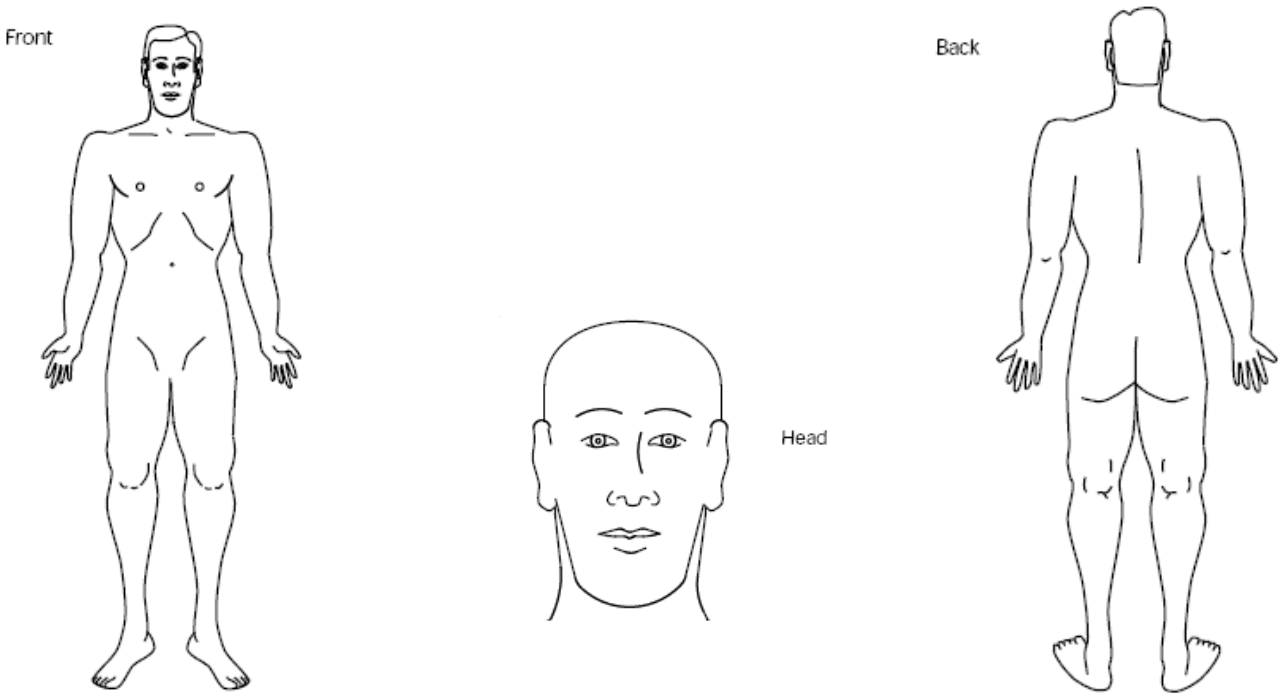
DOCTOR'S STATEMENT
(PLEASE PRINT LEGIBLY)

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.**
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Full Name:	How long have you known the patient?
Patient's Occupation:	
What date and where were you first consulted by the patient in connection with the present injury? / /	
Are you the patient's regular general practitioner? ❑ Yes ❑ No If not, please advise who is	
What is the exact nature of the present injury?	



Do you consider the patient's injury to be a new injury? ❑ Yes ❑ No

A recurrence of an old injury? ❑ Yes ❑ No

If yes, please state condition and advise when previous treatment was given .....

.....

Have you referred the patient to any other services or treatment? ❑ Yes ❑ No

Please specify the type and approximate number of treatments required:

❑ Physiotherapy .....

❑ Chiropractic .....

❑ Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated? .....

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 .....

.....

Was the patient obliged to cease work? ❑ Yes ❑ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to baseball? .....

Does the patient have any congenital defects or chronic diseases? ❑ Yes ❑ No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....

METHOD OF PAYMENT

Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account

Please indicate your preferred method of payment (please tick) ❑ Cheque ❑ EFT

If you would like your payment made by EFT, please complete the details below.

NAME OF CLAIMANT

Title: ❑ Mr. ❑ Mrs ❑ Ms ❑ Miss

Name:_____

BANK ACCOUNT DETAILS

BSB number (all 6 digits are required here) Account Number

❑❑❑❑❑❑ ❑❑❑❑❑❑❑❑❑

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch:_____

DECLARATION

I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment.
- Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network' s disclosure of this information, to Corporate Services Network's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988.* I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.
- I agree that my personal information may also be shared with Baseball Australia's insurance brokers, V-Insurance Group.

Signature: _____ Date: _____

Print Name: _____