

**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.)

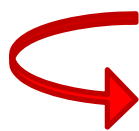
<b>FULL NAME:</b>	<input type="text"/>		
<b>CONTACT NUMBER:</b>	<input type="text"/>	<b>EMAIL:</b>	<input type="text"/>
<b>SPORT:</b>	<input type="text"/>	<b>POSITION:</b>	<input type="text"/>
<b>INJURY DATE:</b>	<input type="text"/>	<b>REFERENCE :</b>	<input type="text"/>

- 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



## 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](mailto:claims@csnet.com.au)



**V-INSURANCE  
GROUP**

**INSURER BROKER FOR ATHLETICS 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

# ATHLETICS 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 years and over 65 years to 100 years \$20,000 maximum). The paraplegia and quadriplegia benefit is \$500,000.

## Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$2,500. Claimable expenses are private hospital bed fee and theatre fees, ambulance, dental, physiotherapy etc, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or \$75 for claimants who do not have private health insurance. Cover is limited to expenses incurred within 52 weeks from the date of injury.

## Student Tutorial Benefit (Full time students)

Reimburses 100% of actual expenses up to \$500 per week for up to fifty two (52) weeks incurred for home tutorial services by a qualified tutor to assist the full-time student – 7 day excess.

## Parents Inconvenience Allowance

Up to \$50 per day to a maximum of \$3,000 for reasonable costs incurred by the parents of an insured person who is hospitalised – 7 day excess.

## Loss of Income

Cover for 85% of your weekly salary or up to a maximum of \$700 per week, whichever is the lesser. The benefit period is 104 weeks and the excess is 7 days.

## Important Notes

This insurance cover is underwritten by: **Liberty Specialty Markets**

Level 38, Governor Phillip Tower, 1 Farrer Place Sydney NSW 2000

1. This summary of insurance cover provides factual information about the Athletics Australia Insurance Program as contained in the Product Disclosure Statement (PDS). Cover is subject to the full terms, conditions and exclusions contained in the PDS. Certain terms used in this summary are defined in the PDS.
2. The policy with full terms, conditions and exclusions is available at [www.vinsurancegroup.com/athleticsaustralia](http://www.vinsurancegroup.com/athleticsaustralia) or by contacting Athletics Australia.
3. This insurance program commences on 31 August 2020 and expires on 31 August 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Athletics Australia who, through injury or accident, incur financial loss and who would otherwise not have 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. Athletics Australia is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

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

[www.vinsurancegroup.com/athleticsaustralia](http://www.vinsurancegroup.com/athleticsaustralia)

# HOW TO MAKE A CLAIM

Dear Athletics Australia 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(s).
3. For claims involving Loss of Income:
  - a) You must complete page 7 and have your employer/salary officer to complete page 7. If self-employed, you must have your accountant complete these details;
  - b) You must complete the Tax File Declaration form on page 8. 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. Government legislation including The Private Health Insurance Act 2007 (Cth) 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 Non-Medicare Medical items such as but not limited to private hospital (for accommodation and theatre fees only), ambulance (if not otherwise covered), physiotherapy, nurse, as 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 completed all sections of the claim form, please have your Club or State Association complete and sign page 4 & 5 confirming that your injury occurred whilst participating in a sanctioned activity.
7. Once you have completed your claim form, please forward to Fullerton Health Corporate Services with all relating documentation and receipts. They handle all claims for the insurer. Their contact details are as follows;

**Corporate Services Network**

GPO Box 4276

Sydney NSW 2001

Phone +61 2 8256 1770

Fax +61 2 8256 1775

Email [claims@csnet.com.au](mailto:claims@csnet.com.au)

8. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network (either by email [claims@csnet.com.au](mailto:claims@csnet.com.au) or post to GPO Box 4276 Sydney NSW 2001). Should you wish to make enquiries relating to the progress of your claim please contact Corporate Services Network directly.
9. If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the Insurance Group Team on (02) 8599 8660 or 1300 945 547.

# PERSONAL ACCIDENT CLAIM FORM

## CLAIMANT DETAILS

Claimant's Given Name: Surname:	Member No (if applicable):	Club Name:	
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth: ___/___/___	
Address	State	Postcode	Email:
Phone Number (work): ( )	Home ( )	Mobile	
Please tick the category applicable: <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Volunteer <input type="checkbox"/> Other If Other, please advise _____			

## DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: ( )
Address	State Postcode
I, the above mentioned Athletics Australia Club Official, confirm that the claimant was a registered and Financial member of this Athletics Australia club and was an insured person as identified in the Personal Accident Insurance with Liberty Specialty Markets 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.	
Signature of Club Official:	Dated: ___/___/___

## STATEMENT BY ATHLETICS AUSTRALIA STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered member of the Athletics Australia Personal Accident Insurance Program. Where the injury occurred during an event, I confirm the event was officially sanctioned by Athletics Australia.	
Name of State/Territory:	Official's Name:
Signature of Association Official:	Dated: ___/___/___

## ACCIDENT DETAILS

Describe the accident and how it happened? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe your injury?

When did your accident occur? Date:    /    /    Time:            am/pm

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 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 \_\_\_\_\_ Resume work/normal activities \_\_\_\_\_

Cease training \_\_\_\_\_ Resume training \_\_\_\_\_

Cease participating \_\_\_\_\_ Resume participating \_\_\_\_\_

Have you ever had this injury or similar injuries in the past?

If yes, please advise when?

    /    /

Which Athletics Australia activity were you participating in at the time of your accident? (please tick)	<input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Throwing <input type="checkbox"/> Jumping <input type="checkbox"/> Other (please advise _____)
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Please tick the category applicable (please tick)	<input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Other e.g. Volunteer (please advise _____)
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Was your activity at the time of the accident? (please tick)	<input type="checkbox"/> Officially organised competition <input type="checkbox"/> Officially organised training <input type="checkbox"/> Social or private competition <input type="checkbox"/> Travelling to and from activity <input type="checkbox"/> Sanctioned fundraising/social event
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**The following information is required for Athletics Australia research to assist with Risk Management. Answering these questions will not affect your claim.**

Surface at point of injury? (please tick)	Grass <input type="checkbox"/> Astroturf / Synthetic Grass <input type="checkbox"/> Running Track <input type="checkbox"/> Other, please advise..... <input type="checkbox"/>
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Weather conditions? (please tick)	Fine <input type="checkbox"/> Rain <input type="checkbox"/> Showers <input type="checkbox"/> Extreme Heat <input type="checkbox"/> Extreme Cold <input type="checkbox"/>
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What were you doing when the accident occurred?	<input type="checkbox"/> Running <input type="checkbox"/> Warming Up <input type="checkbox"/> Walking <input type="checkbox"/> Throwing <input type="checkbox"/> Jumping <input type="checkbox"/> Other
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## 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?

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2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?

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3. Have you engaged in any other income earning employment since you have been injured?

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**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 \$ \_\_\_\_\_

Date commenced employment with company:

\_\_\_\_/\_\_\_\_/\_\_\_\_

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.

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:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Company Stamp:

ABN/ACN:

### B. IF SELF EMPLOYED

Accountant's name:

Phone Number: ( )

Accountant's signature:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Accountant's Company Stamp:







## 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     Other

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 Athletics Australia's insurance brokers, V-Insurance Group.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# V-INSURANCE GROUP

Authorised Representative No. 432898  
 an authorised representative of  
 Willis Australia Limited AFSL: 240600  
 Level 25, 123 Pitt Street, SYDNEY NSW 2000  
 Phone (02) 8599 8660 or local call cost only 1300 945 547  
 Fax (02) 8599 8661  
 Email: [sports@vinsurancegroup.com](mailto:sports@vinsurancegroup.com)

**Office use only**  
**Policy Number:** 2000003538  
**Claim Number:** .....

## SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

**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/PHYSIOTHERAPIST

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

