

Sporting accident claim



QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Policy Number

AVA049021PAD

Claim Number

Claiming Notes:

- The issue of this form does not constitute an admission of liability on the part of the insurer.
 - GPO BOX 4108, Sydney, NSW, 2001 or accidentandhealth@qbe.com or contact 02 9375 4874.
 - 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			
Are you registered for GST?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What is your ABN?	
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%?	Yes <input type="checkbox"/> No <input type="checkbox"/> – If yes, specify amount claimed		<input type="text"/> %
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%?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", specify amount claimed		<input type="text"/> %
Address	<input type="text"/>	State	<input type="text"/> Postcode <input type="text"/>
Contact numbers	Home	<input type="text"/>	Work <input type="text"/>
	Mobile	<input type="text"/>	Email <input type="text"/>
Occupation	<input type="text"/>	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth <input type="text"/>
Sport	<input type="text"/>	Club/Team	<input type="text"/>
Association/League	<input type="text"/>	Registration No. (if applicable)	<input type="text"/>

INJURY DETAILS

Date of injury	<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?	Yes <input type="checkbox"/> No <input type="checkbox"/> – If yes, give details		
<input type="text"/>			
Are you entitled to claim under any other personal accident policy or social security for this injury?	Yes <input type="checkbox"/> No <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?

Yes No

Membership Number

Name of Fund

Have you elected Extra Cover i.e. Physio/Chiro/Dental?

Yes No

Have you elected Hospital and Ambulance Cover?

Yes No

PRIVACY

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at www.qbe.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

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 (dd/mm/yyyy)

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 (dd/mm/yyyy)

to

Salary Officer's Name

Telephone No.

Salary Officer's Signature

Date (dd/mm/yyyy)

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
Player

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? Yes No – If yes, provide the registration no.

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

Rate: student Non student

Signature Date (dd/mm/yyyy)

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 (dd/mm/yyyy) Time am/pm

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

When did the patient first receive medical treatment? Date (dd/mm/yyyy)

When were you first consulted? Date (dd/mm/yyyy) Time am/pm

Was there a previous history of this or a similar condition? Yes No – If yes, when was treatment given?

PHYSICIAN'S STATEMENT (continued)

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

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

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.

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? Yes No – Give details

Name of Hospital	Address	Period of Confinment	
		From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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?

PHYSICIAN'S STATEMENT (continued)

Advise names and addresses of other treating physicians

Name	Address

Have you terminated treatment? Yes No – If yes, on what date?

What is the current prognosis?

Are there any further remarks which may assist us in assessing this condition? Yes No – If yes, give details

Doctor's Name

Qualifications

Address State Postcode

Telephone

Signature

Date