making relationships count

CLAIM FORM: AMATEUR SPORTS PERSONAL ACCIDENT INSURANCE

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

PLEASE ENSURE

- You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.
- ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition" cannot be accepted).

SECTION 1: CLAIMANT DETAILS

Certificate/Policy Number: _____

Policy Name: _____

Club Name: _____ Member No: _____

Claimants Given Name and Full Name: _____

Event or other Activity: _____

Name of team/age group/grade: _____

Gender (please tick): Male ☐ Female ☐ Date of Birth: ____ / ____ / ____

Occupation: _____

Address: _____

_____ State: _____ Postcode: _____

Email: _____

Phone: Work ( ) _____ Home ( ) _____ Mobile _____

Please tick the category applicable: ☐ Player ☐ Official ☐ Member ☐ Volunteer

☐ Other, please specify: _____

TO BE COMPLETED BY THE CLAIMANT

SECTION 2: ACCIDENT DETAILS

Describe how the accident happened: _____

_____

_____

Describe your injury: _____

When did your accident occur? Date: ____ / ____ / ____ Time: _____ (am/pm) _____

What 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: _____ Postcode: _____

State the name of any one witness to the injury: _____

Address of Witness: _____

_____ State: _____ Postcode:

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? Yes ☐ No ☐

If yes, please advise the name of the hospital: _____

If admitted into hospital, how long were you there? _____

Name of person who gave treatment? _____

Advise below when you did (or expect to):

Cease work/normal activities: _____ Cease training: _____

Resume work/normal activities: _____ Resume training: _____

Cease participating: _____ Resume participating: _____

Have you ever had this injury or similar injuries in the past? Yes ☐ No ☐

If yes, please advise when? Date: ____ / ____ / ____

Provide details: _____

_____

ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES

SECTION 3: NON MEDICARE MEDICAL 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: _____

Do you have Hospital Cover? Yes ☐ No ☐

Are you covered for Extras incl. Physio etc Yes ☐ No ☐

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

Name of Provider	Nature of Service (eg Dental, Physio etc.)	Date of Service	Charge	Private Health Fund Recovery (if applicable)	Amount Claimable

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

SECTION 4: LOSS OF INCOME

1. Can compensation be claimed under worker's compensation or any other insurance including Loss of Income? Yes ☐ No ☐
2. Have you ever made any previous claims in respect to personal accident insurance or any other similar insurance? Yes ☐ No ☐
3. Have you engaged in any other income earning employment since you have been injured? Yes ☐ No ☐

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

Name of employer: _____

Address: _____

_____

_____ State: _____ Postcode: _____

Phone: ( ) _____ Fax: ( ) _____

Date ceased work due to injury: _____ / _____ / _____ Date expected to resume normal duties: _____ / _____ / _____

Employee weekly salary as at date of injury: Average Gross Base Salary $ _____ per week _____

Base salary, exclusive of overtime, allowances, bonuses & commissions 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	From _____ / _____ / _____	to _____ / _____ / _____

If 'other' please specify _____

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 Officers Name: _____ Phone: ( ) _____

Email: _____

Salary Officers Signature: _____ Company Stamp:

Date: _____ / _____ / _____ ABN/ACN: _____

B. IF SELF EMPLOYED

Accountant's Name: _____ Phone: ( ) _____

SECTION 5: 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 (Physiotherapist may complete for minor injuries only).
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? _____ Date of Birth: _____ / _____ / _____

What date were you first consulted by the patient in connection with the present injury? _____ / _____ / _____

On what date was medical treatment first sought? _____ / _____ / _____

With whom? _____

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? (Please detail symptoms and diagnosis and how Injury was sustained)

_____

_____

_____

Do you consider the patients 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: _____

_____

Has the patient ever suffered this or a similar condition before? 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: _____

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: _____ / _____ / _____

SECTION 6: 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: _____ Phone: ( ) _____

Fax: ( ) _____ Email: _____

Address: _____

_____ State: _____ Postcode: _____

Signature: _____ Qualifications: _____

Date: _____ / _____ / _____

SECTION 7: METHOD OF PAYMENT

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account.

BANK ACCOUNT DETAILS

Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: _____ _____ _____ - - - _____ _____ _____

Account Number: _____

SECTION 8: DECLARATION

I hereby authorise Cunningham Lindsey Pty Ltd as agents of DUAL Australia Pty Ltd 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 Cunningham Lindsey Pty Ltd has instructed its bank to credit the nominated account and that we release Cunningham Lindsey Pty Ltd from any further liability in relation to this payment.
- Cunningham Lindsey Pty Ltd is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Cunningham Lindsey Pty Ltd collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Cunningham Lindsey's Pty Ltd disclosure of this information, to Cunningham Lindsey's Pty Ltd 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.

Signature: _____ Name (Print): _____

Date: _____ / _____ / _____

SECTION 9: CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

(Please keep a copy of all documents sent to Cunningham Lindsey)

By Post:

Cunningham Lindsey Australia Pty Ltd

Sports Injury Team

PO Box 1438

Parramatta NSW 2124

Email Address:	**Fax No:**
sports@cl-au.com	+61 (2) 9633 5521

Phone Number:

Once the claim form has been completed, sent, and received by Cunningham Lindsey, claim inquiries can be made to Cunningham Lindsey on:

1300 723 690

Policy and coverage queries should first be directed to your Insurance Broker.

SECTION 10: PRIVACY STATEMENT

At DUAL Australia Pty Ltd, we are committed to compliance with the Privacy Act 1988 (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services.

We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2)contracted third party providers who supply us with services such as claims investigation and management companies, legaland medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains information about how you can access the information we hold about you, ask us to correct it, or make a privacy related complaint. You can obtain a copy from our Privacy Officer by telephone (+61 (0)2 9248 6300), email (reception@dualaustralia.com.au) or by visiting our website (www.dualaustralia.com.au).

By signing this claim form, you consent to the collection and use of your personal information as outlined above and in our Privacy Policy.

SECTION 11: DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I _____ 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 DUAL Australia Pty Ltd and their claims managers, Cunningham Lindsey, on behalf of Lloyds of London 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 DUAL Australia Pty Ltd on behalf of Lloyds of London and their service providers in order to assess the claim. DUAL Australia Pty Ltd on behalf of Lloyds of London 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: _____ Dated: _____ / _____ / _____

(or Legal Guardian if under 18 years of age)

SECTION 12: DECLARATION BY ASSOCIATION

Name of Association/Club: _____

Name of Official making this statement: _____

Official's Position: _____ Phone: ( ) _____

Email: _____

Address: _____

_____ State: _____ Postcode: _____

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

If yes, please specify: _____

_____

I, the above mentioned Club Official, confirm that the claimant was a registered and Financial member of this club 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 Association/Club Official: _____ Dated: _____ / _____ / _____