PERSONAL INJURY

INSURANCE

CLAIM FORM FOR

Please ensure all sections are fully completed prior to submitting your claim. Failure to complete all sections of this form may delay settlement of your claim.

Only one claim form (per injury) is required. A claim form should be completed and submitted within 30 days from the date of your injury occurring. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

Please ensure that a General Practitioner, Surgeon, Specialist or Dentist completes the Doctor's Statement. All medical treatment must be certified necessary by a legally qualified medical practitioner.

Please enclose all original receipts for non Medicare medical expenses (if applicable). If you are covered by Private Health Insurance, please also include the statement from your Health insurer.

Once you have completed the claim form, please send it to World Wide Sports Insurance. If you have any further queries please do not hesitate to contact World Wide Sports Insurance.

World Wide Sports Insurance
PO Box N661
Grosvenor Place NSW 1220

Ph: (02) 9247 1700 (24 hours)
or 1300 722 990 – STD Free Outside Sydney Metropolitan Area
Fax: (02) 9247 1733
Email: awilson@wwsi.com.au
Website: www.wwsi.com.au

SPORTS PERSONAL ACCIDENT CLAIM FORM

(Every question MUST be fully answered)

PERSONAL DETAILS

Injured Person's Name _____

Postal Address _____

Phone Numbers Wk ( ) _____ Hm ( ) _____ Mobile _____

Date of Birth _____ Email address_____

Occupation _____Height _____ Weight _____ Sex: Male/Female

Can you claim against any of the following for this injury (select either Yes or No)?:

a) Workers' Compensation insurance:	Yes ☐	No ☐
b) Motor accident compensation insurance:	Yes ☐	No ☐
c) Sick leave (including portable sick leave):	Yes ☐	No ☐
d) Centrelink and / or Government disability benefits:	Yes ☐	No ☐
e) Your employer or another party:	Yes ☐	No ☐
f) Superannuation fund:	Yes ☐	No ☐
g) Any other insurance policy (Travel, Income Protection etc) :	Yes ☐	No ☐

If you have answered Yes to any of the questions under 1, please provide further details (including the insurer's name and your claim number):

_____

Superannuation fund name and membership number: _____

Electronic Funds Transfer

If Sportscover approves your claim and you wish to have your claim benefits transferred directly to your bank account, please provide the following details:

Bank Name: _____ Bank Branch: _____

Account Name:_____ BSB: ____-____ Account No:_____

Authority

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to Sportscover Australia Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims, claims with any other insurer, or any leave benefits and payments, to be released to Sportscover Australia Pty Ltd. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

Declaration

I declare that:

a. ***the claim I am making for injury or sickness IS NOT WORK-RELATED and if my injury or sickness is work-related, I have disclosed this clearly in my answers, and;***

b. ***my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.***

Signature: _____

Name (print): _____ **Date:**_____/_____/_____

STATEMENT BY CENTRE / CLUB

I …… of ……
(Name of Official) (Name of Centre / Club)

hereby certify that ……sustained the injuries resulting in this claim on
(Name of Player)

……./……../…….. at ……..am/pm whilst playing / training for ……...

at ……
(Place of Game)

Signed: …… Dated: ……../……../……..

ACCIDENT DETAILS

1. Describe the accident and how it happened: _____

_____

2. Describe the injury _____

_____

3. When did the accident occur? Date _____ Time _____ am/pm

4. Where did the accident occur? _____

5. Activity at time of accident

Officially Organised Event	❑
Official Representative Competition	❑
Officially Organised Training or Practice	❑
Social or Private Competition	❑
Social or Private Practice	❑
Travelling To or From Above Events	❑

Other _____

6. Name and Address of Witness _ _____

7. Person to whom accident/incident reported _____

8. Time and Date reported _____

9. Brief summary of treatment/action taken
at the time of the accident/incident _____

_____

10. Name and qualifications (if any) of person
who gave treatment _____

11. Was hospitalisation required? _____

Name of hospital and dates confirmed _____

12. Advise when you did (or expect to):

(a) cease work/normal activities _____
(b) cease training _____
(c) cease participating _____
(d) resume work/normal activities _____
(e) resume training _____
(f) resume participating _____

13. Have you ever had this Injury, or similar injury, in the past 5 years? Yes ❑ No ❑

If Yes, when ____/____/_____Treated By_____

14. Have you ever lodged a Personal Accident or Illness claim before? If Yes, please provide details:

_____ _____

_____ ____

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 of Health Fund & Member no:

_____

If you are privately insured, please indicate your level of cover:

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. If your treatment has not been completed, please provide an estimate of ongoing expenses.

Name of Provider	Nature of Service eg. Physiotherapy Dental 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 name and address of Referring Doctor:

_____

_____

_____

_____

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, Specialist or Dentist (not Physiotherapist)**
3. **If 'YES' answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable**

Patient's Full Name: _____

How long have you known the patient? _____

1. (a) What date and where were you first consulted by the Patient in connection with the present injury? _____

2. (a) What is the exact nature of the present injury? _____

_____

_____

(b) If X-Ray examination or other tests have been made, state finding and/or quote report. _____

(c) Is the current condition in any way related to their work? _____

3. Is there a previous history of this or similar condition? If Yes, Please give details _____

4. (a) Do you consider the patient's injury to be a new injury? Yes o No o

(b) A recurrence of an old injury? Yes o No o

5. Is treatment likely to be prolonged by any complications? _____

6. Do you consider that treatment other than that being received is essential to recovery? _____

7. (a) When was the claimant obliged to cease work? _____

(b) When did or when do you expect the claimant to resume: (i) Some Duties? (ii) Full Duties? (i) _____ (ii) _____

8. If the claimant has been hospitalised, please give name of hospital and dates _____

9. Have you referred the patient to other services or treatment? If Yes, to whom? _____

1. Additional remarks and prognosis. _____

I hereby certify I have personally examined the above-named claimant and that in my opinion the statements made in the Accident Details section of this Claim Form are consistent with the Claimant's Injury.

Name: _____ Telephone Number: _____

Address: _____

Signature: _____ Qualifications _____ Date _____