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PERSONAL INJURY CLAIM FORM

INSURANCE BROKER FOR LITTLE ATHLETICS AUSTRALIA

V-Insurance Group Pty Ltd
Authorised Representative No. 432898
an authorised representative of
Willis Australia Limited AFSL: 240600
Level 4, 179 Elizabeth Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547
Fax (02) 8599 8661
Email: sports@vinsurancegroup.com

**CLAIM FORMS ARE TO BE SENT
TO YOUR STATE ASSOCIATION**

LITTLE 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 \$150,000 (other than anyone under 18 years old; \$20,000, limitations also apply for the over 75 year olds). The paraplegia and quadriplegia benefit is \$250,000 for ages 2 to 65.

Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$10,000. Claimable expenses are private hospital, ambulance, dental etc. net of any recoveries from private health insurance – subject to a \$50.00 excess (Nil if Private Health Insurance held). Cover is limited to expenses incurred within 12 months from the date of injury

Student Tutorial Costs (Full time students)

Reimburses up to 100% of costs incurred up to a maximum of \$500 per week for up to hundred and four (104) weeks being costs actually incurred for tutoring etc, to assist the full-time student – 7 day excess.

Household Help Allowance

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of \$500 per week for up to hundred and four (104) 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.

Out of Pocket Expenses

Pays a weekly benefit of \$250 per week up to a maximum of \$5,000 for up to hundred and four (104) weeks, should an Insured Person be a non-income earner and suffer an injury. – \$25 excess.

Loss of Income

Cover for members up to 75 years of age for 80% of your net weekly income up to a maximum of \$1,000 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: ACE Insurance Limited ABN: 23 001 642 020
28-34 O'Connell Street
SYDNEY NSW 2000

1. This summary of cover provides factual information about the Little Athletics Australia insurance program.
2. This information is only a summary of the cover provided. The policy with full conditions is available at www.willis.com.au/ala or by contacting Little Athletics Australia.
3. This insurance program commences on 31st August 2013 and expires on 31st August 2014.
4. V Insurance facilitates this insurance program which provides benefits to those registered members of Little 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. Little 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 Little Athletics Australia insurance program can be obtained by visiting www.willis.com.au/ala

HOW TO MAKE A CLAIM

Dear Little Athletics Australia member,

Please find enclosed 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 and sign and date the Declaration.
3. Please ensure that your Centre and State Association completes and signs the Centre/State Declaration on page 4.
4. For claims involving Loss of Income:
 - a) You must complete page 6 and have your employer/salary officer to complete page 6. If self-employed, you must have your accountant complete these details;
 - b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 8.
5. For claims involving Non-Medicare medical expenses:

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

- a) Have your Attending Physician complete the "Attending Physician" statement on page 8.
6. 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 the insurer 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, dental, ambulance bed and theatre fees (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.

7. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to your State Association.
8. Your State Association will verify your membership and sign the statement on page 4 of the claim form. They will forward your completed claim form and relating documentation directly to V Insurance Group who will then send the documentation to ACE Insurance Limited. Your reimbursement cheque will be sent to you directly by ACE Insurance Limited. Alternatively, you can complete the Method of Payment section on page 10 and the reimbursement payment can be made by Electronic Funds Transfer (EFT) to a nominated bank account.
9. Once your claim is registered, you can submit ongoing invoices to ACE Insurance Limited – 28-34 O'Connell Street, Sydney NSW 2000. ACE Insurance Limited can also be reached on ph: 1800 688 640 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, please do not hesitate to call the V Insurance Group Team on: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Claimants Given Name: Surname:	Member No (if applicable):	Little Athletics Centre Name:
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth: ___/___/___
Address	State Em	Postcode ail:
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 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 ACE Insurance Limited 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 ACE Insurance Limited and their service providers in order to assess the claim. ACE Insurance Limited 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 LITTLE ATHLETICS CENTRE

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

STATEMENT BY LITTLE ATHLETICS AUSTRALIA STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered insurance member of the Little Athletics Australia Personal Accident Insurance Program.

Name of State/Territory:	Official's Name:
Signature of Association Official:	Date: / /

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 event were you involved in? (e.g 100 metres, high jump etc)

Please tick the category applicable (please tick)

Athlete

Other e.g. Volunteer (please advise _____)

* Official

* Coach

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

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 worker's 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:

Date commenced employment with company:

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.

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 officers name:

Phone Number: ()

Salary officers signature:

Date: ____/____/____

Company Stamp:

ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:

Phone Number: ()

Accountant's signature:

Date: ____/____/____

Accountants Company Stamp:

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

Authorised Representative No. 432898
an authorised representative of
Willis Australia Limited AFSL: 240600
Level 5, 179 Elizabeth Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547
Fax (02) 8599 8661
Email: sports@vinsurancegroup.com

Office use only Policy Number: <u>01PO527349</u> Claim Number: _____

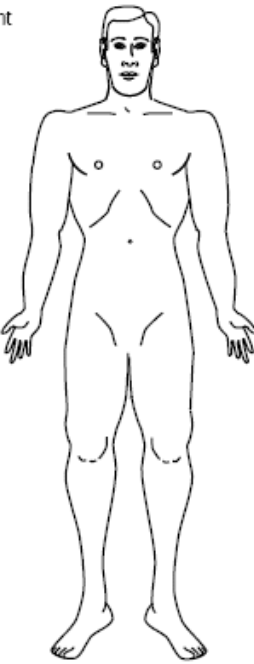
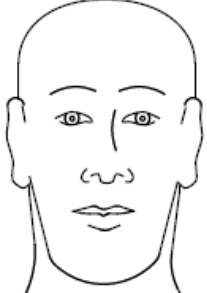
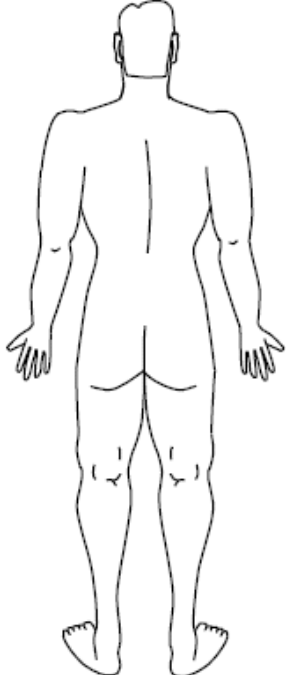
SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the attending physician. (An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist).
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? / /	
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? _____	

Front 	Head 	Back 
--	---	---

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 _____

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 athletics related activities? ____/____/____

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 * 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 ACE Insurance Limited 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 ACE Insurance Limited has instructed its bank to credit the nominated account and that we release ACE Insurance Limited from any further liability in relation to this payment.
- ACE Insurance Limited 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 ACE Insurance Limited collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to ACE Insurance Limited's disclosure of this information, to ACE Insurance Limited'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.

Signature: _____

Date: _____

Print Name: _____