



Personal Accident Insurance Making a Claim

NSW Corporate Games

October 5-7 in Sydney

Making a Claim

Help Us Help You

If you purchased Personal Accident Insurance through the Corporate Games, this note is a simple instruction sheet for you to follow in the event of a claim/injury being suffered as a result of participating in the Corporate Games.

"In the event of a claim/injury, please call Arthur J. Gallagher immediately following the injury. Arthur J. Gallagher will provide you with the information (Claim Form and advice) required to get the matter resolved as quickly as possible. If you do not contact us we cannot help you.

Do not write or try to communicate with any Third Parties in relation to injury or liability matters; advise Arthur J. Gallagher immediately"

Please contact Arthur J. Gallagher for immediate assistance or forward claims to:

Kim Thomson
(02) 8838 5779
Arthur J. Gallagher
Lvl 4, 2-12 Macquire St
Parramatta, NSW 2124

If you have any queries in relation to this information please call us so we may discuss any issues you may have or email kim.thomson@ajg.com.au

Arthur J. Gallagher

Sports Claim Form



Sports Insurance

Claim Form

Please complete Parts 1–8 of this claim form (pages 2 and 3), plus the injury data collection questions on pages 5 and 6

1. Ask Your doctor to complete the 'Medical Statement' (pages 7 and 8)
2. If you are covered for loss of earnings and you wish to make a claim in that regard:
 - a. Ask Your employer to complete Part 9 (page 4). If You are self-employed please have Your accountant complete these details
 - b. Forward a medical certificate every two weeks if Your disability is continuing
3. An authorised official of Your club must complete Part 10 (page 4)
4. Please refer to 'Notes for claimants' on page 9
5. To maximise claims handling efficiency send your completed claim form to the ARTHUR J. GALLAGHER office in your nearest capital city. Refer to the bottom of page 9 for office addresses.

1: The Association

Sport played: _____

Regional body: _____

Association name: _____

Club: _____

Team: _____

Age group: _____

Grade: _____ ☐ Seniors ☐ Reserves (if applicable)

2: The Member

Name: _____

Address: _____ State: _____ Postcode: _____

Phone: (Work): _____ Mobile: _____

Email Address: _____

Occupation: _____

Date of Birth: ____ / ____ / ____ Sex: ☐ Male ☐ Female

Licence Number (if known): _____

3: Details of the Member's Disability or Injury

What is the nature of **Your** injury? _____

What body part/s has been injured? _____

Is it a recurrence of a previous injury? ☐ Y ☐ N

How did it happen? _____

Where were **You** when it happened? _____

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3: Details of the Member's Disability or Injury (continued)

Type of location: ☐ Sportsground ☐ Gymnasium ☐ Swimming pool ☐ Other

If 'Other' please describe: _____

When did the injury occur? ____ / ____ / ____ Time: _____

What were **You** doing? ☐ Playing a match ☐ Warm up ☐ Training ☐ Other sport

If 'Other' please describe: _____

What was the event? ☐ Competition ☐ Regular training ☐ Training camp ☐ Private Training ☐ Other

If 'Other' please describe: _____

4: Details of the Member's treatment

Name and address of each hospital **You** attended: _____

Date of: _____ Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____

Name, address and phone numbers of all attending doctors: _____

Name, address and phone number of **Your** usual doctor _____

_____ State: _____ Postcode: _____

5: Details of the Member's previous Disabilities, injuries or claims

Were **You** suffering any previous medical condition? ☐ Y ☐ N

If 'Yes', give details of the condition: _____

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? ☐ Y ☐ N

If 'Yes', what was the date of injury ____ / ____ / ____

Who was the insurer? _____

How much were **You** paid? _____

What was the injury? _____

Name and address of the doctor: _____

_____ State: _____ Postcode: _____

6: Details of the Member's insurance

Are **You** a member of a health fund?

☐ Y ☐ N

If 'Yes', what type of membership
do **You** have?

☐ Hospital cover only ☐ Ancillary cover only ☐ Hospital plus ancillary benefits

Name of health fund: _____

Membership number: _____

Any other details regarding private health cover: _____

Do **You** have any other insurance to cover this disability or Injury?

☐ Y ☐ N

If 'Yes', please show name and address of insurer _____

_____ State: _____ Postcode: _____

7: Drugs and intoxicating liquor

Were **You** under the influence of any drug or intoxicating liquor when the disability or injury took place

☐ Y ☐ N

If 'Yes', please give details: _____

Have **You** taken any performance enhancing drugs?

☐ Y ☐ N

8: The Member's declaration

By signing this claim form I declare that:

1. All the information that I have given in this form is correct
2. I authorise any doctor, hospital or other person who has treated me to provide ARTHUR J. GALLAGHER. or its representative with any medical records for any illness or injury I have suffered.
3. I authorise my employer to provide ARTHUR J. GALLAGHER or its representative with details of my salary and working hours.
4. I agree that a photocopy of this authorisation will be accepted as valid.
5. I agree to allow the insurer to ask or tell other insurers or insurance reference bureaux about this or any other claim I have made.

Must be completed by the injured **Member** or their guardian if the member is under 18 years

Signature: _____ Date: ____ / ____ / ____

9: The Member's employment details (Must be completed by pay clerk/paymaster)

Employer's name: _____

Employer's address: _____

_____ State: _____ Postcode: _____

Phone number: _____

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury. (Excluding bonuses, commissions, overtime or any other allowances) \$ _____

Date **You** expect **Your** employee to resume work _____ / _____ / _____

Date **You** expect **Your** employee to resume normal duties (fully fit) _____ / _____ / _____

What is **Your** employee's gross annual salary? \$ _____

What date did he or she commence employment? _____ / _____ / _____

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury (net of business expenses, but before income tax and personal deductions e.g. Tax Return)

What is the name of **Your** pay clerk? _____

What is **Your** pay clerk's phone number? _____

Signature of pay clerk / paymaster: _____ Date: _____ / _____ / _____

10: The Club's declaration

Must be completed by the club Secretary or Treasurer

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

I _____ Secretary or Treasurer

of _____ Name of club and association

Confirm that _____ Member's name

Sustained the injuries resulting in this claim on:

_____ Date at _____ Time

While playing or training for _____ Team

against _____ Opposition Team

or while taking part in _____ Activity

against _____ Opposition Team

at _____ Place of game or activity

The first consultation with a doctor for this injury was on:

_____ Date

at _____ Address of doctor

Signature: _____ Date: _____ / _____ / _____

Club mailing address: _____

_____ State: _____ Postcode: _____

Sports Insurance

Claim Form

State Association/OAMPS Office Use Only

Player Registration Number: _____

Signed: _____

Position: _____

State Association Stamp Where Applicable: _____

Injury data collection

is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. ARTHUR J. GALLAGHER Insurance Brokers Ltd, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was **Your** role at the time of Your injury?

- ☐ Participant
 ☐ Coach
 ☐ Umpire/Referee
 ☐ Other Official
☐ Voluntary Worker
 ☐ Spectator
 ☐ Other

If 'Other' please provide details:

How far into the activity were **You** at the time of the injury?

(Note: Your answer relates to the time into the activity, rather than the period/stage of the game))

- ☐ Warm up
 ☐ 1st Quarter
 ☐ 2nd Quarter
☐ 3rd Quarter
 ☐ 4th Quarter
 ☐ Cool Down

On what surface were **You** participating?

- ☐ Grass
 ☐ Synthetic Surface
 ☐ Wooden Floor
☐ Gravel
 ☐ Concrete/Bitumen
 ☐ Other

If 'Other' please provide details:

What was the condition of the surface?

- ☐ Normal
 ☐ Hard
 ☐ Wet
 ☐ Muddy
 ☐ Other

If 'Other' please provide details:

What were the weather conditions as the time of injury?

- ☐ Fine
 ☐ Light Rain
 ☐ Heavy Rain
 ☐ Other

If 'Other' please provide details:

What were the temperature conditions at the time of injury?

- ☐ Very Hot
 ☐ Hot
 ☐ Hot & Humid
 ☐ Mild
☐ Cold
 ☐ Very Cold
 ☐ Other

If 'Other' please provide details:

How was the onset of injury?

- ☐ Sudden
 ☐ Gradual
 ☐ Started Play With Pre-Existing Injury

If a collision injury, what did **You** collide with?

- ☐ Ground
 ☐ Equipment
 ☐ Player
 ☐ Other Structure

If 'Other' please provide details:

What was **Your** activity leading to the injury?

- ☐ Landing
 ☐ Jumping
 ☐ Twist/Turn
 ☐ Side Stepping
☐ Starting
 ☐ Stopping
 ☐ Running
 ☐ Being Tackled
☐ Applying Tackle
 ☐ Receiving Ball
 ☐ Passing/Throwing
 ☐ Hitting
☐ Kicking
 ☐ Scrum
 ☐ Ruck
 ☐ Maul
☐ Other

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If 'Other' please provide details:

Was protective equipment, tape or support being worn on the injury site?

☐ Yes ☐ No

If yes, please provide details:

☐ Taping ☐ Protective Equipment ☐ Other Support

If 'Protective equipment', please provide details:

If 'Other support', please provide details:

How did the injury severity affect Your playing?

☐ Unable to Continue Playing ☐ Continued to Play After Treatment
☐ Continued to Play Without Treatment

What was the immediate treatment? (more than one box may be ticked)

☐ Rest ☐ Ice ☐ Compression ☐ Elevation
☐ Stretching ☐ Mobilisation ☐ Taping ☐ Bandaging
☐ Sling ☐ Splint ☐ Other ☐ Unknown

If 'Other' please provide details:

Was a sports trainer present at the game?

☐ Yes ☐ No ☐ Unknown

If Your injury required referral, to whom were **You** referred?

☐ Hospital ☐ Doctor ☐ Physiotherapist ☐ Dentist ☐ Other

If 'Other' please provide details:

If immediate off site treatment was necessary, what mode of transport was used?

☐ Ambulance ☐ Private Vehicle ☐ Other

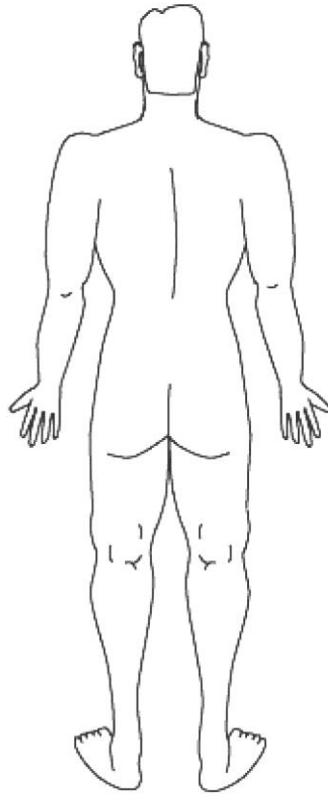
If 'Other' please provide details:

Sports Insurance

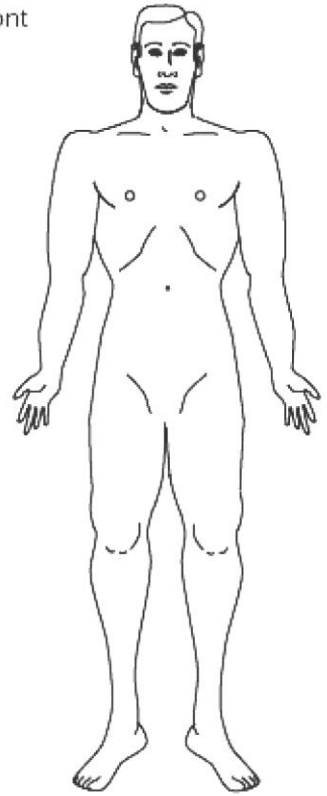
Claim Form

Please indicate the site of your injury on the appropriate diagram below:

Back



Front



Head



Medical statement

This form must be completed by the registered medical doctor treating the injury

The Association and Club

Association name: _____

Club name: _____

Type of sport: _____

The Member

Name: _____

Address: _____ State: _____ Postcode: _____

Date of Birth: ____ / ____ / ____ Sex: ☐ Male ☐ Female

The injury

Complete Diagnosis _____

History

When did the present disability or injury occur? ____ / ____ / ____

Date the player ceased work: ____ / ____ / ____

Is there a history of the same or similar condition? _____

Is this a recurrence? ☐ Y ☐ N

Present condition

Subjective symptoms: _____

Objective finding (*give reports of any x-rays, ECGs or other tests*) _____

Is the player ☐ Walking ☐ Bed confined ☐ House confined ☐ Hospital confined

Date of admission: ____ / ____ / ____

Treatment of present condition

Date of first consultation: ____ / ____ / ____

Date of latest consultation: ____ / ____ / ____

Frequency of consultations: _____

Date of last hospitalisation: ____ / ____ / ____

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Name of hospital: _____

Nature of surgical procedure: _____

_____ ☐ Contemplated ☐ Performed

Progress

If performed: ____ / ____ / ____

Has condition improved? ☐ Y ☐ N

If 'No', please explain:

Degree of disability

Has the patient been able to do any work?

If 'No', from what date

Regular work: ____ / ____ / ____ Light duties: ____ / ____ / ____

When will the patient be able to resume for

Regular work: ____ / ____ / ____ Light duties: ____ / ____ / ____

Other treatment

If the patient was seen in consultation. ____ / ____ / ____

by another doctor, please give the date,
name and address of that doctor

_____ State: _____ Postcode: _____

If the patient is no longer under your care, what date were your services terminated? ____ / ____ / ____

Other conditions

Describe any other disease or infirmity affecting the patient's present condition: _____

Please complete the appropriate section if the disability or injury is due to:

Cardiac-circulatory

Blood pressure: _____

Circulatory disorder – please describe: _____

Visual

Is the patient totally or industrially blind? ☐ Y ☐ N

If 'No', what was the vision at
last observation:

With glasses: ☐ Distant ☐ Near Date: ____ / ____ / ____

Without glasses: ☐ Distant ☐ Near Date: ____ / ____ / ____

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What is the extent of any gross visual field defect? _____

Could vision be improved by treatment, surgery or lenses? ☐ Y ☐ N

What are the rehabilitation prospects? _____

Orthopedic

Please report findings of specialist if referred? _____

Neurological

Please report findings of specialist if referred? _____

Prognosis

Remarks

Signature: _____ Date: ____ / ____ / ____

Degree: _____

Name of Doctor

(please print): _____

Address: _____

Postcode: _____

Please apply doctors name stamp below

Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

Loss of income claim (if eligible)

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete**

2. **Please forward your completed Sports Injury Claim Form to our office within 30 days of your injury. Do not wait for all your medical accounts. Forward them to us as you receive them.**
3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for ARTHUR J. GALLAGHER. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer your complaint to the Insurance Broking Division of the Financial Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the ARTHUR J. GALLAGHER web site at www.ajg.com.au or telephone 1800 240 432.

Claims Handling

Claims are processed at ARTHUR J. GALLAGHER Brisbane office (refer Brisbane address below). To maximize claims handling efficiency send your completed claim form and documentation direct to that office.

Arthur J. Gallagher Capital City Offices

Adelaide

180 Greenhill Road
Parkside, SA 5063
T: 08 8172 8000
F: 08 8172 8100
adelaide@ajg.com.au

Brisbane

Level 2, 601 Coronation
Drive Toowong Qld 4066
T: 07 3367 5000
F: 07 3367 5100
brisbane@ajg.com.au

Canberra

Ground Floor, 10 Geils Court
Deakin ACT 2600
T: 02 6283 6555
F: 02 6283 6556
canberra@ajg.com.au

Darwin

Level 2, 71 Smith Street
Darwin, NT 0800
T: 08 8942 5000
F: 08 8942 5050
darwin@ajg.com.au

Hobart

137 Harrington St
Hobart, TAS 7000
T 03 6235 1222
F 03 6235 1221
hobart@ajg.com.au

Melbourne

289 Wellington Parade
South
East Melbourne, VIC 3002
T: 03 9412 1555
F: 03 9412 1666
melbourne@ajg.com.au

Perth

Level 1, Teddington Road
Burswood, WA 6100
T: 08 6250 8300
F: 08 6250 8400
perth@ajg.com.au

Sydney

Level 4, 2-12 Macquarie
Street
Parramatta, NSW 2150
T: 02 8838 5700
F: 02 8838 5701
sydney@ajg.com.au

Direct to your nearest Branch

1800 240 432

PO Box 852, East Melbourne VIC 8002

www.ajg.com/