Sporting accident claim

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

Policy Number		Claim Number	

Claiming Notes:

- **The issue of this form does not constitute an admission of liability on the part of the insurer.**
- **Please complete this claim and forward to your Broker within 30 days of injury.**
- **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 No	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 No	If "No", go to question 3			
2. Will you be claiming an amount less than 100%?	Yes No	- If yes, specify amount claimed	%		
3. Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	Yes No	If "No", go to Address			
4. Will you be claiming an amount less than 100%?	Yes No	If "Yes", specify amount claimed	%		
Address		State		Postcode	
Contact numbers	Home		Work		
	Mobile		Email		
Occupation		Sex M F	Date of Birth		
Sport		Club/Team			
Association/League		Registration No. (if applicable)			

INJURY DETAILS

Date of injury ______ Time of Injury ______ am/pm

Were you: Playing Training Travelling

Type of Injury ______

How did injury occur? Collision Tripped Fell Other - give details

______

Have you suffered this injury or similar injury in the past? Yes No - If yes, give details

______

Are you entitled to claim under any other personal accident policy or social security for this injury? Yes No

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

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