BUDGET
SPORTING ACCIDENT CLAIM FORM
Please read this page first before completing the Claim Form

Dear Member,

Thank you for your Claim Form request. This letter contains important information relevant to your Claim. Please read it carefully and make sure you understand its contents.

WE REQUIRE THE CLAIM FORM TO BE RETURNED
(**FULLY COMPLETED**) TO SPORTSCOVER WITHIN 120 DAYS OF YOUR INJURY.
DO NOT WAIT UNTIL TREATMENT IS COMPLETE BEFORE SUBMITTING THE CLAIM FORM.

1. The Medical Report on page 7 must be completed by the main Doctor, Chiropractor, Physiotherapist or Dentist who is providing treatment for your injury.

2. Please send all original receipts for Non Medicare Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts.

3. We will commence working on your Claim immediately however, Claims cannot be settled (entitlements calculated) until all treatment relating to the injury has been completed, all accounts have been paid and refunds from your Private Health Insurer have been obtained.

4. In most cases, there are varying Excesses on claims for Medical Expenses. For precise details and information regarding Policy maximums and excesses, please contact your Club or Association.

5. Sportscover Australia values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement please visit our website at www.sportscover.com.

If you have any queries, please call us immediately.

CLAIMS HOTLINE: 1300 134 956
EMAIL: asiapac.claims@sportscover.com

Please send all claims correspondence to:

CLAIMS DEPARTMENT
SPORTSCOVER AUSTRALIA PTY LTD
Locked Bag 6003
Wheelers Hill VICTORIA 3150

SPORTSCOVER • Melbourne • Sydney • London • Shanghai •
Melbourne: 271-273 Wellington Rd, Mulgrave
Locked Bag 6003, Wheelers Hill, VIC 3150
T: +61 (0)3 8562 9100 F: +61 (0)3 8562 9111
Claims Hotline: 1300 134 956 (Aust Only)
Sydney: Suite 305, 25 Lime Street, Sydney
PO Box Q896, QVB, NSW 1230
T: +61 (0)2 9268 9100 F: +61 (0)2 9268 9111
Email: asiapac.claims@sportscover.com
ACN 006 637 903 ABN 43 006 637 903 AFS Licence Number 230914

25 YEARS OF INSURING SPORT
UAC UNDERWRITING AGENCIES COUNCIL FOUNDATION MEMBER
Underwriting Agency of the Year Inaugural Winner

Sportscover Australia Pty Ltd
A.C.N. 006 637 903
A.B.N. 43 006 637 903
AFS Licence No. 230914

Claim Form

PLEASE USE BLOCK LETTERS | ALL SECTIONS MUST BE COMPLETED

BEFORE YOU COMMENCE FILLING IN THIS FORM, PLEASE MAKE SURE YOU HAVE READ AND FULLY UNDERSTOOD THE DIALOGUE ON THE FRONT OF THE CLAIM FORM AS IT CONTAINS IMPORTANT INFORMATION RELATING TO YOUR CLAIM. IF YOU HAVE ANY QUESTIONS AT ALL ABOUT ITS CONTENTS OR MEANING, PLEASE CONTACT YOUR NEAREST SPORTSCOVER OFFICE.

PART 1 – CONTACT / CLAIMANT DETAILS

Name of Claimant _____ _____
Surname Given Names

Date of Birth ___/___/_____ Sex **Male** **Female**

Occupation _____

Home Address _____

_____ State _____ Post Code _____

Address for Correspondence _____

_____ State _____ Post Code _____

Telephone (AH) _____ Telephone (BH) _____

Mobile _____ Email _____

Australian Permanent Resident **Yes** **No** **Other** *(if other, please specify)* : _____

Sport _____

Team/Club _____

Association (in full) _____

1. (a) Please give a full description of the circumstances of the accident which led to the injury.

_____

_____

_____

(b) Please provide a copy of the teamsheet/scoresheet where the details of the accident have been recorded

(c) When did the injury occur? Date ___/___/_____ Time _____ am/pm

(d) Please provide the address of where the injury occurred _____

_____ Post Code _____

(e) At the time of the injury, were you:

Playing	☐	Training	☐	Social Game/Match	☐
Pre Season Playing	☐	Pre Season Training	☐	Officiating	☐
Other	☐				

If "Other", please provide details _____

PART 1 – CONTACT / CLAIMANT DETAILS (continued)

1. (f) On what surface were you participating?

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

If "Other", please provide details _____

(g) What was the condition of the surface?

Normal	☐	Hard	☐	Wet	☐
Muddy	☐	Other	☐		

If "Other", please provide details _____

(h) What were the weather conditions at the time of injury?

Fine	☐	Light Rain	☐	Heavy Rain	☐
Other	☐				

If "Other", please provide details _____

(i) 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 _____

(j) What activity lead to the injury?

Landing	☐	Jumping	☐	Twist/Turn	☐
Side Stepping	☐	Starting	☐	Stopping	☐
Running	☐	Kicking	☐	Tackle	☐
Impact by Object	☐	Collision with Player	☐	Other	☐

If "Other", please provide details _____

(k) Was a sports trainer present at the game? **Yes** **No** **Unknown**

2. (a) What injuries did you receive? _____

_____

(b) When did you first consult a practitioner for this injury? _____

(c) Is treatment complete for this injury? **Yes** **No**

(If **No** please notify us in writing as soon as it is.)

PART 1 – CONTACT / CLAIMANT DETAILS (continued)

3. Were you taken to hospital by Ambulance? **Yes** **No**

Were you admitted to Hospital? **Yes** **No**

If **Yes** Date from / / to / /

Name of Hospital _____

Address _____

Post Code _____

In Patient ☐ Out Patient ☐ Name of Attending Doctor _____

4. Are you now, or have you ever been, subject to or affected by other Injury or Disease, Deformity, Defect of Senses, Infirmity or Weakness? **Yes** **No**

If **Yes**, please give details _____

5. Have you ever lodged a personal accident claim before **Yes** **No**

If **Yes**, please give details _____

6. (a) Are you a member of a Private Health Insurance Fund? **Yes** **No**

If **Yes**, please give details

Fund Name _____ Member Number _____

(b) If **Yes**, are you entitled to claim for any of the following benefits? **Yes** **No**

Private Hospital ☐ Physiotherapy ☐ Dental ☐

Chiropractic ☐ Ambulance ☐ Massage ☐

Other ancillary services. Please give details _____

7. If you intend making a loss of wages claim, are you making or entitled to make a claim in respect of this injury for any of the following?

Sick Leave **Yes** **No** Workers Compensation **Yes** **No**

Motor Government Benefits **Yes** **No** Superannuation Life Insurance **Yes** **No**

Income Protection (*for example: Personal or via Superannuation Fund)* **Yes** **No**

Centrelink Sickness **Yes** **No**

If **Yes**, please give details _____

PLEASE NOTE
Original receipts and all statements of any benefit received from any source must be sent to Sportscover as soon as possible. Failure to do so will result in a delayed settlement of your Claim. Please also remember to **inform us in writing when your treatment is complete**. This will also reduce delays in settlement of your claim.

PART 2 – SETTLEMENT DETAILS

NOTE: For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

☐ Mail cheque ☐ Direct bank deposit (*if **bank deposit**, please give details below)*

BANK NAME _____

BENEFICIARY NAME _____

BSB NUMBER ☐☐☐☐☐☐ *minimum 6 digits*

ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐ *maximum 9 digits*

PART 3 – DECLARATION AND AUTHORISATION BY INJURED PERSON

Name _____ _____
Surname *Given Names*

I hereby authorise any hospital, physician, medical practitioner, medical specialist or any other person who has attended me and/or any employer of mine, past or present, to furnish Sportscover Australia Pty Ltd (SCA) and/or its representatives with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers including verification of my earnings.

I acknowledge that any personal information that I have or will provide to Sportscover Australia Pty Ltd (SCA) is necessary for and will be used in the processing, assessing, investigation or review of this claim. I hereby authorise SCA and/or its representatives and consent to SCA and/or its representatives and/or its authorised agent to disclose my personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed/authorised broker, account broker and/or broker of the entity/body corporate/organisation insured (Insured), State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personal information (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, I can contact the SCA Privacy Officer.

I agree that a photocopy/scanned copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

Signature Date / /

WARNING: Persons found to have lodged a fraudulent claim are liable for prosecution.

PART 4 – WITNESS STATEMENT - We require a statement from anyone who witnessed the incident. Please have that person/s complete this section.

1. (a) Name _____ _____
Surname *Given Names*

(b) Address _____

_____ State _____ Postcode _____

(c) Telephone (AH) _____ Telephone (BH) _____

(d) Please give a full description of the accident giving a rise to the claimant's injury, as you saw it:

_____

_____

_____

_____

_____

_____

Signature of Witness Date / /

2. (a) Name _____ _____
Surname *Given Names*

(b) Address _____

_____ State _____ Postcode _____

(c) Telephone (AH) _____ Telephone (BH) _____

(d) Please give a full description of the accident giving a rise to the claimant's injury, as you saw it:

_____

_____

_____

_____

_____

_____

Signature of Witness Date / /

Official Report

PLEASE USE BLOCK LETTERS | PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED

PLEASE NOTE:
These questions must be completed by an authorised office bearer of the insured Club/Association.
The Team sheet or Injury Report is a separate document.

PART 5 – INCIDENT REPORT

CLAIMANT'S NAME _____

Date of Injury ____ / ____ / ____

1. Name of Association _____ Club _____
2. Was the player, listed above, registered at the time of the accident? **Yes** **No**
3. Were you a witness to the accident described *(If **Yes**, please give details)* **Yes** **No**

_____

_____

_____

_____

If you were not a witness, are you satisfied the player was injured on the above date whilst participating in a club game or training session? **Yes** **No**

If **No**, please give reasons _____

_____

_____

_____

PART 6 – DECLARATION BY AN AUTHORISED OFFICE BEARER

I certify that the particulars shown on this form are, to the best of my knowledge, true and correct and hereby authorise this claim to be paid directly to _____ *(claimant)*.

Signature Date / /

Print Name _____

Position _____

Address _____

Suburb _____ State _____ Post Code _____

Policy Number _____ Telephone _____

Medical Report

PLEASE USE BLOCK LETTERS | PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED

PLEASE NOTE:
These questions are to be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor.
The injured person is responsible for the completion of this form without expense to Sportscover.

PART 7 – MEDICAL REPORT

Patient's Details

Name _____ _____
Surname *Given Names*

Address _____

_____ State _____ Postcode _____

Telephone (AH) _____ Telephone (BH) _____

What is disabling the patient? *(Please give a complete diagnosis of this condition)*

_____

_____

History

1. When did the patient first receive medical treatment for this injury? ____/____/____
2. (a) Was there a previous history of this or similar condition? **Yes** **No**
   (b) *If **Yes**, please state the condition and advise when previous treatment was given* _____

   _____
3. (a) How long have you known the patient? ____/____/____
   (b) Are you the claimant's regular practitioner? **Yes** **No**
   (c) *If **No**, please advise who is* _____

Injury

1. When did the patient suffer the injury ____/____/____
2. What were the circumstances surrounding the injury? _____

   _____

   _____

Treatment of present condition

1. When were you consulted? (a) Initially ____/____/____ (b) Most recently ____/____/____
2. How often has the patient consulted you? _____
3. Was patient confined to hospital? **Yes** **No**
4. *If **Yes**, please advise* (a) Name of hospital _____
   (b) Period of Confinement From ____/____/____ to ____/____/____
5. Was confinement in a convalescent home necessary after hospitalisation **Yes** **No**
   *If **Yes**, please give details* _____
6. What are the current subjective symptoms? _____

PART 7 – MEDICAL REPORT – Continued.

7. Please give results of any objective findings:
   (a) X-Rays, MRI's _____
   (b) Other tests – *please advise tests done and findings* 1. _____
   2. _____
8. What surgical procedures have been performed? _____
9. What surgical procedures have been contemplated? _____
10. Are there any underlying conditions affecting recovery from the current condition? **Yes** **No**
    *If **Yes**, could you advise the nature of underlying conditions and how they affect disability and recovery:*
    _____
11. Has patient any other physical or mental impairment? **Yes** **No**
    *If **Yes**, please describe* _____
12. Please advise names and addresses of other treating physicians
    Name _____
    Address _____
    _____ Telephone _____
13. If you have terminated treatment, please advise date ____/____/____
14. What is the current prognosis? _____
15. Are there any further remarks which may assist in assessing this condition?
    _____
16. Is there any permanent disability at present? **Yes** **No**
    *If **Yes**, please explain giving an estimated percentage loss of function:* _____
    _____

Physician's Details

Full Name _____
Qualifications _____
Street Address _____
Suburb _____ State _____ Postcode _____
Telephone _____ Email _____
Website _____

Signature _____ Date ____/____/____

206 Health Insurance Act 1973 continued

Medical Expenses

(Australian government legislation (see below) ***does not allow*** General Insurers to cover ***any costs*** subject to a Medicare rebate.)

Examples of Medicare Medical Expenses (Excluded from Policy) **(Figures used are for example purposes only)**	
Private Practitioner Visit (GP) - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $50.00 Medicare Rebate: $35.00 Balance: $15.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Surgeon - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $750.00 Medicare Rebate: $600.00 Balance: $150.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Anaesthetist - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $400.00 Medicare Rebate: $300.00 Balance: $100.00 (Not Claimable)	Medicare Item – not covered in part or whole.
Public Hospital Accommodation - You may be asked to pay towards this service above the Medicare Scheduled Fee. Eg. Bill: $400.00 Medicare Rebate: $325.00 Balance: $75.00 (Not Claimable)	Medicare Item - not covered in part or whole.
Examples of Medical Services which may be covered by the Sportscover Policy	
Private Hospital Accommodation , Private Hospital Theatre Fees, Ambulance	Refer to policy for limits.
Physiotherapy, Chiropractor, Massage, Acupuncture, Myotherapy, Osteopath, Hydrotherapy, Podiatry	Refer to policy for limits.
Dental (Sound Whole Teeth Only), MRI's (under certain conditions)	Refer to policy for limits.
Hire of Crutches, Wheelchair, Equipment for Rehabilitation, Brace	Refer to policy for limits.
The policy relevant to your Club or Association will have a specific **Excess, Maximum Percentage Payable and a Maximum Limit Payable.** For the specific policy benefits please refer to your Claims covering letter and policy wording which details the policy benefits, coverage and conditions.	

206 Health Insurance Act 1973

Part VII – Miscellaneous

Prohibition of certain medical insurance.

126 (1) A person shall not make a contract of insurance with another person that contains a provision purporting to make the first mentioned person liable to make a payment in the event of the incurring by the other person of a liability to pay medical expenses in respect of the rendering in Australia of a professional service for which Medicare benefit is, or but for subsection 18(4) would be payable.

Penalty $1000.

(2) Where there is contract of insurance (whether made before or after the commencement of this section) under which the insurer is liable to make a payment in the event of the incurring by that person of liability to pay medical expenses in respect of the rendering in Australia of a professional service, there is an implied condition in the contract that the insurer is not liable for loss arising out of the incurring of liability to pay medical expenses in respect of the rendering in Australia of a professional service in respect of which a Medicare benefit is, or but for subsection 18(4) would be, payable.

(3) Where:

(a) the proper law of a contract of insurance would, but for a term that it should be the law of some other country or a term to the like effect, be part of the law of any part of Australia; or

(b) a contract of insurance contains a term that purports to substitute, or has the effect of substituting, provisions of the law of some other country or of a State or Territory for all or any of the provisions of this section;

this section applies to the contract notwithstanding that term.

(4) Any term of a contract of insurance (including a term that is not set out in the contract but is incorporated in the contract by another term of the contract) that purports to exclude, restrict or modify or has the effect of excluding, restricting or modifying the application in relation to that contract of all or any of the provisions of this section is void.

(5) A term of a contract shall not be taken to exclude, restrict or modify the application of a provision of this section unless the term does so expressly or is inconsistent with that provision.

(5A) This section does not apply in relation to a contract of insurance entered into by a registered organization as insurer in so far as the contract provides for benefits in accordance with the basic table.