Sports Underwriting Australia
Sports Injury Claim Form

Sports Underwriting Australia Claims Department
PO Box 2717, Taren Point. NSW, 2229
Tel: 1300 363 413 | Fax: 02 9524 9003
Email: paclaims@sportsunderwriting.com.au

Members Name:							
Address:						Post Code:	
Telephone:	Home -		Work -		Mobile -		
Email:							
Date of Birth:		Height:		Weight:		Sex:	☐M / F☐
Normal occupation prior to disablement:							
Name of Club, Grade & Team:				Registration Number:			
Association:				Period/Expiry of Registration:			

DETAILS OF INJURY:

A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).

Type of Injury:		How did injury occur?	
Place where you were injured:			
Date of Injury:		Time:	

Training: Yes ☐ No ☐ Playing: Yes ☐ No ☐ Other: Yes ☐ No ☐

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition (s):		Date:		Treated By:	

To be completed by an Official.
Please ensure that all questions have been fully answered.

Name of Member				was injured as stated.	
Registration Number:					
Name of Club			Association		
Officials Name		Position		Telephone	
Address				Post Code	

I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.

Signature		Date		Witness		Date	

The following information is required for Australian Oztag Association Inc. research to assist with Risk Management.
Answering these questions will not affect your claim

Did the injury occur whilst you where:

Playing ☐ Training ☐ Social Game ☐ Pre Season ☐ Official / Referee ☐

Other, please advise

Surface at point of injury? (Please Tick)

Grass ☐ Synthetic ☐ Concrete / Asphalt ☐

Other, please advise

Weather Conditions? (Please Tick)

Fine ☐ Rain ☐ Showers ☐ Extreme Heat ☐ Extreme Cold ☐

Surface Conditions? (Please Tick)

Wet ☐ Dry ☐

Other, please advise

When did the injury occur? (Please Tick)

1st Half ☐ 2nd Half ☐ Training ☐ Not applicable ☐

Other, please advise

Details of Non Medicare expenses claimed.
NB Only forward accounts for services which are not subject to a Medicare rebate
Ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

Are you a member of a private health fund? Yes ☐ No ☐

If yes, which one?

Hospital Cover Yes ☐ No ☐ Extras covering dental, physio, etc. Yes ☐ No ☐

Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)					
b)					
c)					
d)					

When did you first consult a physician for this condition?	
When did you become totally disabled (unable to work)?	
When were you able to again perform part of your occupational duties?	
If still totally disabled, when do you expect your disability to terminate?	
When will you resume playing?	

Hospital	Addresses	From	To

a. Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

b. Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)

Name	Address	Telephone

LOSS OF INCOME CLAIMS

1. IF SELF EMPLOYED

(Please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant?

Name	Address	Telephone

2. IF EMPLOYED AS A WAGE EARNER

(To be completed by your employer)

I HEREBY CERTIFY THAT: …… has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on ……

He/She has been incapacitated since …… and is expected to/did resume duties on ……

His/Her gross basic salary (excluding bonuses, commission and overtime at the date of injury was $ …… per week.

During this period of incapacity he/she received:

a) Normal pay $ …… b) Sick pay $ …… c) Workers Compensation $ ……
From …… to …… From …… to …… From …… to ……

d) Other (please specify) $ ……
From …… to ……

He/She has been employed since ……

His/Her sick leave entitlements at date of injury is …… days.

Name of Company: …… Company Stamp:

Address: ……

Name of Manager or Paymaster (Please Print): ……

Signature of Manager or Paymaster: ……

Telephone: …… Date: ……

Are you claiming or entitled to claim any other form of benefit (eg. Work Cover, Superannuation Injury Cover, etc.)? If so, please provide details.

……

……

DECLARATION AND AUTHORISATION

I hereby authorise any hospital, physician or any other person who has attended me, or any employer, to furnish Sports Underwriting Australia Pty Ltd, Calliden Limited 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 earnings.

I acknowledge that any personal information that I have or will provide to Sports Underwriting Australia Pty Ltd and/or Calliden Limited (Calliden) is necessary for and will be used in the processing, assessing, investigation or review of this claim. I consent to Sports Underwriting Australia Pty Ltd, Calliden or its authorised agent to disclose my personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, broker, 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, Sports Underwriting Australia Pty Ltd &/or Calliden will provide to me their dispute resolution procedures.

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

Signature of Player: _____ Date : _____
(or parent/guardian if under 18 years of age)

Attending Physicians Statement

To be completed by a registered medical practitioner

(The insured is responsible for completion of this form without expense to the company)

Patients Name		Address		Sex	M/F ☐ ☐
What is disabling patient? (Please give a complete diagnosis of this condition)					

HISTORY:

1. When did patient first receive medical treatment?			
2. Was there a previous history of this or a similar condition?	Yes ☐	No ☐	
If yes, please state condition and advise when previous treatment given.			
3. a) How long have you known the patient?			
b) Are you the regular general practitioner? If no please advise who is?	Yes ☐	No ☐	

IF INJURY:

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

IF DISABILITY:

1. Patients occupation?			
2 When was patient obliged to cease work?			
3. If patient still disabled, when will the patient be able to commence any type of employment?			
a) some duties		b) full duties	
4. If patient has recovered, when was patient able to resume.			
a) some duties		b) full duties	

TREATMENT OF PRESENT CONDITION

1. When were you consulted?			
a) initially?		b) most recently?	
2. How often has patient consulted you?			
3. Was patient confined to hospital?	Yes ☐	No ☐	
If yes please advise Hospital Name			
Address			
Period of confinement	From	To	
4. Was confinement in a convalescent home necessary after hospitalisation?	Yes ☐	No ☐	
If yes please give details.			
5. What are the current subjective symptoms.			
6. Please give results of any objective finding.			
a) X-rays			
b) Other test - Please advise test done and findings			
7. What surgical procedures have been performed?			
8. What surgical procedures have been contemplated?			
9. What other treatment has the patient undergone?			
10. What other treatment is required?			
Are there any underlying conditions affecting recovery from the current condition?	Yes ☐	No ☐	
If yes please advise nature of underlying conditions and how they affect disability and recovery.			
Has patient any other physical or mental impairment?	Yes ☐	No ☐	
If yes, please describe.			
Please advise names and addresses of other treating physicians.			
Name	Address	Telephone	
If you have terminated treatment, please advise date.			
What is your current prognosis?			
Are there any further remarks which may assist in assessing this condition?			
Is there any permanent disability present?	Yes ☐	No ☐	
If yes, please explain giving estimated percentage of loss of function.			
Name (please print name):	Address:	Telephone:	
Signature:	Degree:	Date:	