



Office use only Policy Number: Claim Number:



PERSONAL INJURY CLAIM FORM

INSURANCE BROKER FOR SOFTBALL AUSTRALIA

V-Insurance Group Pty Ltd Authorised Representative No. 432898 a corporate authorised representative of Willis Australia Limited AFSL: 240600 Level 25, Angel Place, 123 Pitt Street, SYDNEY NSW 2000 Phone (02) 8599 8660 or local call cost only 1300 945 547 Fax (02) 8599 8661 Email: <u>sports@vinsurancegroup.com</u>

CLAIM FORMS ARE TO BE SENT TO;

Gallagher Basset Services

GPO Box 14 Brisbane QLD 4001

Phone: +61 7 3012 3114 fax: +61 7 3005 1705

email: ahclaims@gbtpa.com.au

SOFTBALL 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 \$200,000 (other than anyone under 18 and over 75 years old \$20,000 maximum). The paraplegia and quadriplegia benefit is \$250,000.

Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses up to a maximum of \$4,000. Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance. 100% Ambulance costs reimbursement under this benefit. – Benefit subject to a nil excess for claimants who are covered by private health insurance only claiming ambulance, or otherwise \$20. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

Student Assistance Benefit

Reimburses 100% of costs incurred up to a maximum of \$400 per week for up to fifty two (52) weeks being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student -7 day excess.

Home Help Benefit

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of \$400 per week for up to fifty two (52) 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.

Parents Inconvenience Allowance

Pays up to \$25 per day of costs to a maximum of \$1,500, whilst the child is hospitalised to off-set costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age. The maximum benefit period is fifty two (52) weeks and the policy excess is 7 days.

Loss of Income

Cover for 100% of your net weekly income or up to a maximum of \$500 per week, whichever is the lesser. The benefit period is one hundred and four (104) weeks and the excess is 7 days.

Funeral Benefit

If a death benefit has been paid under capital benefits, an amount of \$10,000 is available for reimbursement of funeral expenses.

Important Notes

This insurance cover is underwritten by: Pen Underwriting Pty Ltd

ABN 89 113 929 516 AFSL 290518 as Coverholder on behalf of certain Underwriters of Lloyd's. Level 19, 347 Kent Street Sydney NSW 2000

- 1. This summary of cover provides factual information about the Softball Australia Insurance Program.
- 2. The policy with full conditions is available at <u>www.vinsurancegroup.com/softball</u> or by contacting Softball Australia.
- 3. This insurance program commenced on 1 October 2017 and expires on 1 October 2018.
- 4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Softball Australia who, through injury or accident, incur financial loss and who would not have otherwise 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. Softball Australia are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the Softball Australia insurance program can be obtained by visiting www.vinsurancegroup.com/softball



HOW TO MAKE A CLAIM

Dear Softball Australia member,

Please find attached 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 Association official completes and signs the Association Declaration on page 5.
- 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 us 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 room and theatre fees, dental, ambulance (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 completed all sections of the claim form, please have your Club and State Association complete and sign page 4 & 5 confirming that your injury occurred during a sanctioned activity.
- 8. Once you have completed your claim form, please forward to Gallagher Bassett Services Pty Ltd . They handle all claims for the insurer and will send your reimbursement cheques. Their contact details are as follows;

Gallagher Bassett Services Pty Ltd GPO Box 14 Brisbane QLD 4001 Phone: +61 7 3012 3114 Fax: +61 7 3005 1705 Email: AHClaims@gbtpa.com.au

- **9.** Once your claim is registered, you can submit ongoing invoices via Gallagher Bassett Services. Gallagher Bassett Services can also be reached on the above contact details 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 ph: (02) 8599 8660 or 1300 945 547.



PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS					
Claimant's Given Name:	Surname:			Member No (if applicable):	
Name of Association:	Name of Club / I	_eague:	Name	e of team/age group/grade:	
Occupation:	Date of Birth: / /	Gender (please tid	,	Email:	
Address			Sta	ate Postcode	
Phone Number (work): He	ome)		Мо	bile	
Please tick the category applicable \Box	Player 🗌 Offi	cial 🗌 Coach		Umpire Dother	
If Other, please advise					
DECLARATION AGREEMENT AI	ND AUTHORIS	ATION BY CLAI	MANT		
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 Gallagher Bassett Services Pty Ltd 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, medica 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 Gallagher Bassett Services Pty Ltd and their service providers in orde to assess the claim. Gallagher Bassett Services Pty Ltd 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					
DECLARATION BY CLUB					
Name of Club:	Name of Club O	fficial making this st	ateme	nt:	
Official Position:	Telephone Number: () Email:				
I, the above mentioned Softball Australia Club Off Club and confirm that the claimant was taking part the time of the accident, that the information containformation referred to in this claim form is true ar	t in an insured activity ained in this statement	as defined by the Perso	nal Acci	dent Insurance with Softball Australia at	
Do you have any comments in relation the second sec				Yes No	
Dated: / / Signatu	e of Club Official:				

SOFTBALL

DECLARATION BY STATE/ TERRITORY ASSOCIATION				
Name of State/ Territory Association:	Name of State Association Official making this statement:			
Official Position:	Telephone Number: ()			
	Email:			
Address State Postcode				
an insured person as identified in the Personal Accident Insurance with	mant was a registered and Financial member of Softball Australia and was Pen Underwriting at the time of the accident, that the information contained and belief the information referred to in this claim form is true and correct.			
Do you have any comments in relation to this claim?	🗌 Yes 🗌 No			
If yes, please detail				
Dated: / /	Signature of State/ Territory Association Official:			



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ACCIDENT DETAILS

Describe the accident and how it happened?				
Describe your injury?				
When did your accident occur?				
Date: / / Time: am/pn	n			
Was your activity at the time of the accident?	Officially organised competition ()			
(please tick)	Officially organised training ()			
	Social or private competition ()			
	Travelling to and from activity ()			
	Sanctioned fundraising/social event ()			
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 was 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 Cease training Cease participating Resume work/normal activities Resume training Resume participating			
Have you ever had this injury or similar injuries in the past?	If yes, please advise when: / /			



The following information is required for Softball Australia research to assist with Risk Management. Answering these questions will not affect your claim.				
Surface at point of injury? (please tick)	Grass	()	
	Astroturf / Synthetic Grass	()	
	Other, please advise	()	
Weather conditions? (please tick)	Fine	()	
	Rain	()	
	Showers	()	
	Extreme Heat	()	
	Extreme Cold	()	
What were you doing when the accident occurred?	Batting	()	
	Fielding	()	
	Pitching	()	
	Catching	()	
	Running Bases	()	
	Warming Up	()	
	Other	()	



LOSS OF INCOME (ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LO	DSS OF INCOME)		
	(Please tick the box) YES NO		
 Can compensation be claimed under Workers' Cor or any other insurance including Loss of Income? 			
2. Have you ever made any previous claims in respectant any other insurance?	t to personal accident insurance or		
Have you engaged in any other income earni been injured?	ing employment since you have		
THE FOLLOWING SECTION MUST BE COMPLETED B	Y YOUR EMPLOYER / SALARY OFFICER.		
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNT	ANT 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: 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.	Date commenced employment with company: / /		
Income Definition:			
Self Employed Full Time Part Time Casual			
During the period of incapacity the employee has receive	d		
\$Normal PayFrom\$Sick PayFrom\$Workers CompensationFrom\$Other (please specify)FromHas the employee returned to work?	/		
Has the employee lodged or intending to lodge a Worker	s' Compensation Claim?		
A. IF EMPLOYED			
Salary officer's name:	Phone Number: ()		
Salary officer's signature:	Date: ABN/ACN:		
Company Stamp:			
B. IF SELF EMPLOYED			
Accountant's name:	Phone Number: ()		
Accountant's signature: Accountant's Company Stamp:	Date: / /		



NON MEDICARE MEDI (ONLY COMPLETE THIS SEC			SES)			
Do not attach accounts paid contribute to any charges c					e Act does not	permit us to
Are you a member of an An	nbulance Service?		Yes	🗌 No		
Are you a member of a Priv	ate Health Fund?		Yes	🗌 No		
If yes, please provide detail	s					
Hospital Cover?			Yes	🗌 No		
Extra's covering, Physio etc	2		Yes	🗌 No		
Original accounts and receip Insurance.	ots must be submitte	ed together with deta	ails of re	ecoveries fro	om any Private	Health
NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL	DATE OF SERVICE	CH	ARGE	PRIVATE HEALTH FUND	amount Claimable

SERVICE E.G DENTAL PHYSIOTHERAPY ETC	SERVICE	HEALTH FUND RECOVERY (IF APPLICABLE)	CLAIMABLE
		Total	
		Less Excess	

TOTAL AMOUNT OF CLAIM



Office	use only
Policy	Number:
Claim	Number: _

Authorised Representative No. 432898a corporate authorised representative ofWillis Australia Limited AFSL: 240600Level 25, Angel Place, 123 Pitt Street, SYDNEY NSW 2000Phone(02) 8599 8660 or local call cost only 1300 945 547Fax(02) 8599 8661Emailsports@vinsurancegroup.com

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT

(PLEASE PRINT LEGIBLY)

IMPORTANT

- 1. The patient is responsible for any fee for this statement.
- 2. This form can <u>only</u> be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.
- 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

Patient's Full Name:	How long have you known the patient?		
Patient's Occupation:			
What date and where were you first consulted by the patier / /	nt in connection with the present injury?		
Are you the patient's regular general practitioner?	Yes 🗌 No		
What is the exact nature of the present injury?			
For Head	Back		



Do you consider the patient's 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 to	reatment?	🗌 Yes	🗆 No	
Please specify the type and approximate number of treat	atments required	d:		
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 asse	ssing this condit	ion?		
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?	Como dution	🗌 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 softbal	1?			
Does the patient have any congenital defects or chronic	c diseases?	🗌 Yes	🗆 No	
If yes, please give dates, name of treating doctor and d				
If the patient has been hospitalised, please give name of	of hospital and d	ates hospit	alised:	
Name of Hospital: Date	e Admitted	Date R	eleased	
	/ /	/	/	
CERTIFICATION BY ATTENDING PHYSICIAN				
I hereby certify I have personally examined the above named patient this claim form are consistent with the patient's injury.	and in my opinion th	ne statements	made in the Accid	ent details section of
Name:	Telephone Nu	mber:()		
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)
If you would like your payment made by EFT, please complete the details below.
NAME OF CLAIMANT
Title: Mr. Mrs Miss Ms
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 Gallagher Bassett Services Pty Ltd 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 Gallagher Bassett Services has instructed its bank to credit the nominated account and that we release Gallagher Bassett Services from any further liability in relation to this payment.
 Gallagher Bassett Services 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 Gallagher Bassett Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Gallagher Bassett Services' disclosure of this information, to Gallagher Bassett Services' 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 <i>Privacy Act 1988</i> . 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.
 I agree that my personal information may also be shared with Softball Australia's insurance brokers, V-Insurance Group.
Signature: Date:
Print Name:

