

## 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 their 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 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 visit the Touch Football Australia website [www.austouch.com.au](http://www.austouch.com.au) or call 02 6212 2800.

If you have any queries, please call us immediately.

**CLAIMS HOTLINE: 1300 134 956**

**EMAIL: [asiapac.claims@sportscover.com](mailto:asiapac.claims@sportscover.com)**

Please send all claims correspondence to:

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

**MELBOURNE –** 271 – 273 Wellington Road, Mulgrave, VIC 3170

**SYDNEY –** Suite 103, 507 Kent Street, Sydney, NSW 2000

**LONDON –** LUC, 3 Minster Court, Mincing Lane, London EC3R 7DD

**TORONTO –** Suite 270, 33 Yonge Street, Toronto, Ontario, M5E1G4

**Email –** [asiapac.claims@sportscover.com](mailto:asiapac.claims@sportscover.com)

**Website –** [www.sportscover.com](http://www.sportscover.com)

**Ph: +61 3 8562 9100**

**Ph: +61 2 9268 9100**

**Ph: +44 (0)20 7398 4080**

**Ph: +1 (416) 987 7595**

**Fax: +61 3 8562 9111**

**Fax: +61 2 9268 9111**

**Fax: +44 (0)20 7398 4090**

**Fax: +1 (416) 336 4608**

**Claims Hotline – 1300 134 956**

## 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

Sport \_\_\_\_\_

Name of Claimant \_\_\_\_\_  
Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Address for Correspondence \_\_\_\_\_  
State \_\_\_\_\_ Post Code \_\_\_\_\_

Telephone (AH) \_\_\_\_\_ Telephone (BH) \_\_\_\_\_

Facsimile \_\_\_\_\_ Email \_\_\_\_\_

Team/Club \_\_\_\_\_

Association (in full) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex **Male** **Female**

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 \_\_\_\_\_

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 not please notify us in writing as soon as it is.)

**PART 1 – CONTACT / CLAIMANT DETAILS (continued)**

3. Were you admitted to Hospital? **Yes** **No**  
 If yes 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, Infirmary 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) Are you entitled to claim for any of the following benefits? **Yes** **No**

Private Hospital  Physiotherapy  Dental

Chiropractic  Ambulance  Massage

Other ancillary procedures. 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: Once your claim has been settled, we can, if you wish, transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no postal or cheque clearance days. If you wish to avail yourself of this service, please provide us with the following details of your bank account.

- 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 or other persons who have attended me, or any employer, to furnish Sportscover Australia Pty Ltd or their authorised representative with any illness or injury, medical history, consultation, prescriptions or treatment, copies of hospital or 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.

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 your accident. Please have that person complete this section.**

(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 / /

SAMPLE

## 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, as by recognised by the Touch Football Australia Affiliate Regulations, of the affiliated Touch Football Australia Club or Association. The Team sheet or Injury Report is a separate document.

**PART 6 – 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 7 – DECLARATION BY AN AUTHORISED OFFICE BEARER**

I certify as an authorised office bearer of the Touch Football Australia affiliated Club or Association 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*).

Our Club or Association has provided affiliation and insurance to Touch Football Australia for the competition in which this incident occurred."

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name \_\_\_\_\_

Position \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Affiliate \_\_\_\_\_ Certificate of Currency Number \_\_\_\_\_

## 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 8 – MEDICAL REPORT

#### Patient's Details

Name \_\_\_\_\_

Address \_\_\_\_\_ Surname \_\_\_\_\_ Given Names \_\_\_\_\_

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? \_\_\_\_\_

#### Degree of Disability

1. Patient's Occupation \_\_\_\_\_

2. When was the patient obliged to cease work? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. If patient is still disabled, when approximately will the patient resume:

(a) Some duties? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (b) Full duties? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. If patient has recovered, when was the 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 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PART 8 – MEDICAL REPORT – Continued.**

5. Was confinement in a convalescent home necessary after hospitalisation **Yes** **No**  
*If yes, please give details* \_\_\_\_\_
6. What are the current subjective symptoms? \_\_\_\_\_
7. Please give results of any objective findings:  
 (a) X-Rays \_\_\_\_\_  
 (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 \_\_\_\_\_  
 \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_  
 Telephone \_\_\_\_\_ Email \_\_\_\_\_  
 Website \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 \_\_\_\_\_



## MY SPORTSCOVER FOLLOW UP SHEET

**This is designed to help you and the Sportscover Claims Department in making sure that your claim is handled quickly and efficiently for an early settlement. Enquiries can be made by contacting the Claims Department Hotline on 1300 134 956.**

- EG. I have received a claim form.
- I have sent my Sportscover Claim Form back within 120 days of my injury to:

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

**The following requirements are to be returned within 12 calendar months from the date of injury:**

- I have receipts and/or statements from Private Health Insurance
- I have obtained a Doctors Referral
- I have notified Sportscover in writing when all my treatment is complete

## 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.

**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.)

<b>Examples of Medicare Medical Expenses (Excluded from Policy)</b> <b>(Figures used are for example purposes only)</b>	
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.
<b>Examples of Medical Services which may be covered by the Sportscover Policy</b>	
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 <b>Excess, Maximum Percentage Payable and a Maximum Limit Payable</b> . For the specific policy benefits please refer to your Claims covering letter and policy wording which details the policy benefits, coverage and conditions.	

# Privacy and Insurance at Sportscover Australia

## Proposal, Renewal, Endorsement and Claim forms

Sportscover and its agents are bound by the obligations of the **Privacy Act 1988 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act)** and will be covered by the **General Insurance Information Privacy Code (the Code)**. These set basic standards relating to the collection, use, disclosure and handling of personal information.

'Personal information' is essentially information or an opinion about a living **individual** whose identity is apparent or can reasonably be ascertained from the information or opinion.

Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives).

Only information necessary for the arrangement and administration of Sportscover's business by Sportscover, its Brokers or agents and their representatives will be collected. This includes information necessary to accept the risk, to assess a claim, to determine competitive and appropriate premiums.

Sportscover and its Brokers or agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Sportscover and its Brokers or agents personal information about other individuals, we rely on you to have made or make them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by Sportscover by contacting your Broker or contacting Sportscover directly, by any of the following:

Phone: (03) 8562 9100  
+ 61 3 8562 9100 (International)  
Fax: (03) 8562 9111  
Email: [privacy@sportscover.com](mailto:privacy@sportscover.com)