Sports Insurance

Claim Form – Rugby League

Arthur J. Gallagher
BUSINESS WITHOUT BARRIERS™

1. Please complete Parts 1 – 8 of this claim form (pages 2 and 3), plus the injury data collection questions on pages 5 and 6
2. Ask Your doctor to complete the 'Medical Statement' (pages 7 and 8)
3. If you are covered for loss of earnings and you wish to make a claim in that regard:
   a) **Ask Your employer to complete Part 9 (page 4). If You are self-employed please have Your accountant complete these details**
   b) **Forward a medical certificate every two weeks if Your disability is continuing**
4. An authorised official of Your club must complete Part 10 (page 4)
5. Please refer to 'Notes for claimants' on page 9
6. To maximise claims handling efficiency send your completed AHA Northern Territory AHA Tasmania Liquor Stores Association WA

1. The Association

Sports played: ______________________________

Regional body: ______________________________

Association: ______________________________

Club: ______________________________

Team: ______________________________

Age Group: ______________________________

Grade: ______________________ ☐ Seniors ☐ Reserves (if applicable)

2. The Member

Name: ______________________________

Address: ______________________________

______________________ State: __________ Postcode: __________

Contact Name: ______________________________

Phone: (Work): ______________________ Mobile: ______________________

Email: ______________________________

Occupation: ______________________________

Date of Birth: ______/ ______/ ______ Sex: ☐ Male ☐ Female

Licence Number: (if known) ______________________________

3. Details of the Member's Disability or Injury

What is the nature of Your injury? ______________________________

What body part/s has been injured? ______________________________

Is it a recurrence of a previous injury? Y ☐ N ☐

How did it happen? ______________________________

____

____

Where were you when it happened? ______________________________

____

Type of location: ☐ Sportsground ☐ Gymnasium ☐ Swimming pool ☐ Other

If 'Other' please describe: ______________________________

When did the injury occur? ______/ ______/ ______ Time: ______________

What were **You** doing: ☐ Playing a match ☐ Warm up ☐ Training ☐ Other sport

If 'Other' please describe: ______________________________

What was the event? ☐ Competition ☐ Regular training ☐ Training camp

☐ Private Training ☐ Other

If 'Other' please provide details: ______________________________

4. Details for the Member's treatment

Name and address of each hospital **You** attended: ______________________________

Date of Admission ______/ ______/ ______ Date of Discharge: ______/ ______/ ______

Name, address and phone numbers of all attending doctors:

____

____

____

____

____

Name, address and phone number of **Your** usual doctor ______________________________

____

______________________________ State: ______________ Postcode: ________

5. Details of the Member's previous Disabilities, injuries or claims

Were **You** suffering any previous medical condition? Y ☐ N ☐

If 'Yes' give details of the condition: ______________________________

____

____

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? Y ☐ N ☐

If 'Yes', what was the date of injury ______/ ______/ ______

Who was the insurer? ______________________________

How much were **You** paid? ______________________________

What was the injury? ______________________________

Name and address of the doctor: ______________________________

____

______________________________ State: ______________ Postcode: ________

6. Details of the Member's insurance

Are **You** a member of a health fund Y ☐ N ☐

If 'Yes', what type of membership do **You** have?

☐ Hospital cover only ☐ Ancillary cover only ☐ Hospital plus ancillary benefits

Name of health fund: ______________________________

Membership number: ______________________________

Any other details regarding private health cove: ______________________________

____

____

Do **You** have any other insurance to cover this disability or Injury? Y ☐ N ☐

If 'Yes', please show name and address of insurer: ______________________________

____

______________________________ State: ______________ Postcode: ________

7. Drugs and intoxicating liquor

Were **You** under the influence of any drug or intoxicating liquor when the disability or injury took place Y ☐ N ☐

If 'Yes', please give details: ______________________________

____

____

Have You taken any performance enhancing drugs? Y ☐ N ☐

8. The Member's declaration

By signing this claim form I declare that:

1. All the information that I have given in this form is correct
2. I authorise any doctor, hospital or other person who has treated me to provide Arthur J. Gallagher. or its representative with any medical records for any illness or injury I have suffered.
3. I authorise my employer to provide Arthur J. Gallagher or its representative with details of my salary and working hours.
4. I agree that a photocopy of this authorisation will be accepted as valid.
5. I agree to allow the insurer to ask or tell other insurers or insurance reference bureaux about this or any other claim I have made.

Must be completed by the injured **Member** or their guardian if the member is under 18 years

Signature ____ Date: ______/ ______/ ______

9. The Member's employment details (Must be completed by pay clerk/paymaster)

Employer's name: ____

Employer's address: ____

____

____ State: ______________ Postcode: _______

Phone number: ____

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury? (Excluding bonuses, commissions, overtime or any other allowances) $ ____________________

Date **You** expect **Your** employee to resume work: ______/ ______/ ______

Date **You** expect **Your** employee to resume normal duties (fully fit) ______/ ______/ ______

What is **Your** employee's gross annual salary? $ ____________________

What date did he or she commence employment? ______/ ______/ ______

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury (net of business expenses, but before income tax and personal deductions e.g. Tax Return)

What is the name of Your pay clerk? ____

What is Your pay clerk's phone number? ____

Signature of pay clerk/paymaster: ______________________ Date: ______/ ______/ ______

10. The Club's declaration

Must be completed by the club Secretary or Treasurer

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

I ______________________________ Secretary of Treasurer

of ______________________________ Name of Association

Confirm that ______________________________ Member's name

Sustained the injuries resulting in this claim on:

Date: ______/ ______/ ______ Time: ______________________________

While playing or training for ______________________________ Team

against ______________________________ Opposite Team

or while taking part in ______________________________ Activity

against______________________________ Opposite Team

at ______________________________ Place of game or activity

The first consultation with a doctor for this injury was on:

______________________________ Date

at ______________________________ Address of doctor

Signature ______________________________ Date: ______/ ______/ ______

Club mailing address: ______________________________

____

______________________________ State: ____________ Postcode: ________

Phone number: ______________________________

State Association/Arthur J. Gallagher Office Use Only

Player Registration Number: ______________________________

Signed: ______________________________

Position: ______________________________

State Association Stamp Where Applicable:

____

____

____

____

Injury data collection

Arthur J. Gallagher is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. Arthur J. Gallagher, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was **Your** role at the time of Your injury?

☐ Participant ☐ Coach ☐ Umpire/Referee ☐ Other Official

☐ Voluntary Worker ☐ Spectator ☐ Other

If 'Other' please provide details: ______________________________

How far into the activity were You at the time of the injury? *(Note: Your answer relates to the time into the activity, rather than the period/stage of the game))*

☐ Warm up ☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter

☐ 4th Quarter ☐ Cool Down

On what surface were You participating?

☐ Grass ☐ Synthetic Surface ☐ Wooden Floor

☐ Gravel ☐ Concrete/Bitumen ☐ Other

If 'Other' please provide details: ______________________________

What was the condition of the surface?

☐ Normal ☐ Hard ☐ Wet ☐ Muddy ☐ Other

If 'Other' please provide details: ______________________________

What were the weather conditions as the time of injury?

☐ Fine ☐ Light Rain ☐ Light Rain ☐ Other

If 'Other' please provide details: ______________________________

What was Your role at the time of Your injury?

☐ Very Hot ☐ Hot ☐ Hot & Humid ☐ Mild

☐ Cold ☐ Very Cold ☐ Other

If 'Other' please provide details: ______________________________

How was the onset of injury?

☐ Sudden ☐ Gradual ☐ Started Play with Pre-exiting injury

If a collision injury, what did You collide with? ☐ Ground ☐ Equipment ☐ Player ☐ Other Structure

If 'Other' please provide details: ____________________

What was Your activity leading to the injury?

☐ Landing ☐ Jumping ☐ Twist/Turn ☐ Side Stepping ☐ Starting
☐ Stopping ☐ Running ☐ Being Tackled ☐ Applying Tackle
☐ Receiving Ball ☐ Passing/Throwing ☐ Hitting ☐ Kicking
☐ Scrum ☐ Ruck ☐ Maul ☐ Other

If 'Other' please provide describe: ____________________

____

Was protective equipment, tape or support being worn on the injury site? Yes ☐ No ☐

How was the onset of injury? ☐ Taping ☐ Protective Equipment ☐ Other Support

If 'Protective equipment', please provide details: ____________________

____

If 'Other support' please provide details: ____________________

____

How did the injury severity affect Your playing? ☐ Unable to Continue Playing ☐ Continued to Play After Treatment ☐ Continued to Play Without Treatment

If 'Other' please provide details: ____________________

____

What was the immediate treatment? (more than one box may be ticked)

☐ Rest ☐ Ice ☐ Compression ☐ Elevation ☐ Stretching
☐ Mobilisation ☐ Taping ☐ Bandaging ☐ Sling ☐ Splint
☐ Other ☐ Unknown

If 'Other' please provide details: ____________________

____

Was a sports trainer present at the game? ☐ Yes ☐ No ☐ Unknown

If Your injury required referral, to whom were **You** referred? ☐ Hospital ☐ Doctor ☐ Physiotherapist ☐ Dentist ☐ Other

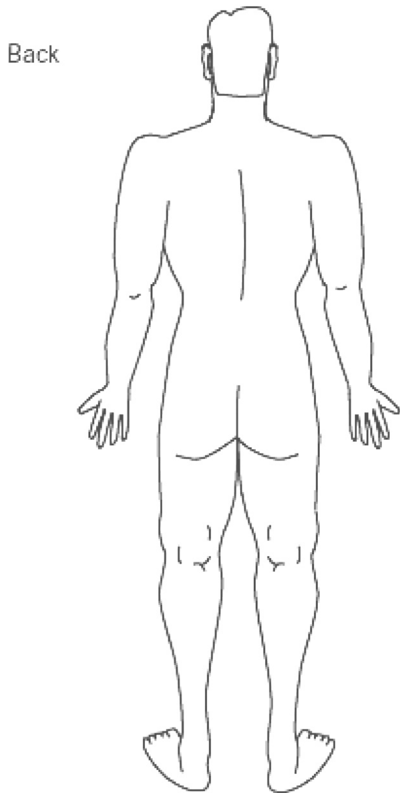
If 'Other' please provide details: ____________________

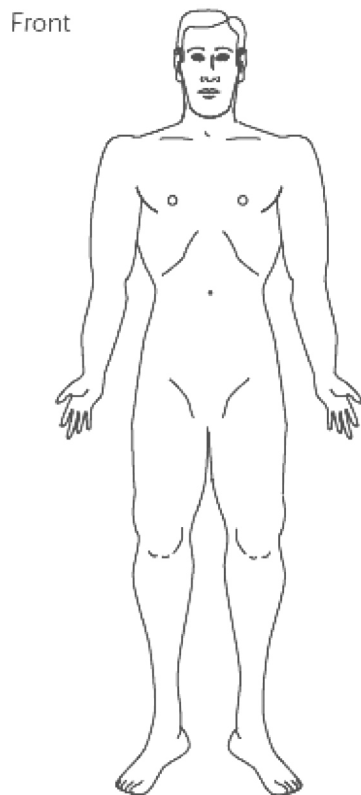
____

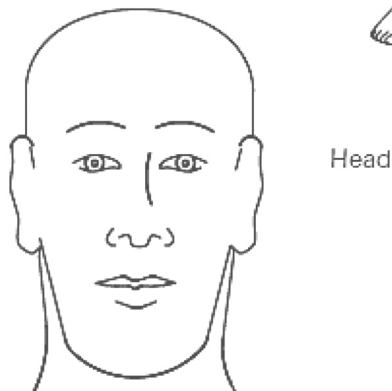
If immediate off site treatment was necessary, what mode of transport was used? ☐ Ambulance ☐ Private Vehicle ☐ Other

If 'Other' please provide details: ____________________

Please indicate the site of your injury on the appropriate diagram below:







Medical statement

This form must be completed by the registered medical doctor treating the injury

The Association and Club

Association name:______________________________

Club name: ______________________________

Type of sport: ______________________________

The Member

Name: ______________________________

Address: ______________________________

______________________________ State: ____________ Postcode: ________

Date: ______/ ______/ ______ Sex: ☐ Male ☐ Female

The injury

Complete Diagnosis ______________________________

____

____

____

History

When did the present disability or injury occur? Date: ______/ ______/ ______

Date the player ceased work: Date: ______/ ______/ ______

Is there a history of the same or similar condition? Date: ______/ ______/ ______

Is this a recurrence? Y ☐ N ☐

Present condition

Subjective symptoms: ______________________________

____

Objective finding (give reports of any x-rays, ECGs or other tests) ______________________________

____

____

Is the player ☐ Walking ☐ Bed confined ☐ House confined ☐ Hospital confined

Date of admission: ______/ ______/ ______

Treatment of present condition

Date of first consultation: ______/ ______/ ______

Date of latest consultation: ______/ ______/ ______

Frequency of consultation ______________________________

Date of last hospitalisation: ______/ ______/ ______

Name of hospital: ______________________________

Nature of surgical procedure______________________________

______________________________ ☐ Completed ☐ Performed

Progress

If performed: ______/ ______/ ______

Has condition improved? Y ☐ N ☐

If 'No', please explain: ______________________________

____

Degree of disability

Has the patient been able to do any work? ______________________________

____

If 'No', from what date Regular work: ______/ ______/ ______ Light duties: ______/ ______/ ______

When will the patient be able to resume for Regular work: ______/ ______/ ______ Light duties: ______/ ______/ ______

Other treatment

If the patient was seen in consultation by another doctor, please give the date, ______/ ______/ ______

Name and address of that doctor. ______________________________

____

____

______________________________ State: ______________ Postcode: _______

If the patient is no longer under your care, what date were your services terminated? ______/ ______/ _____

Other conditions

Describe any other disease or infirmity affecting the patient's present condition: ______________________

____

____

Please complete the appropriate section if the disability or injury is due to:

Cardiac-circulatory

Blood pressure: ______________________________

Circulatory disorder: (please describe) ______________________________

____

Visual

Is the patient totally or industrially blind? Y ☐ N ☐

If 'No', what was the vision at last observation:	With glasses:	☐ Distant	☐ Near	Date: ______/ ______/ ______
	Without glasses:	☐ Distant	☐ Near	Date: ______/ ______/ ______

What is the extent of any gross visual field defect? ______________________________

Could vision be improved by treatment, surgery or lenses? Y ☐ N ☐

What are the rehabilitation prospects? ______________________________

____

____

____

Orthopedic

Please report findings of specialist if referred? ______________________________

____

____

Neurological

Please report findings of specialist if referred? ______________________________

____

____

Prognosis ______________________________

____

____

Remarks ____

____

____

Signature ______________________________________ Date: ______/ ______/ ______

Degree: ____

Name of Doctor (please print): ____

Employer's address: ____

____

______________________________________ State: ______________ Postcode: ____________

Please apply doctors name stamp below

Addendum to injury data collection - Rugby League

What position were you playing at the time of the injury?

Front Row	☐	Hooker	☐
Second Row	☐	Lock	☐
Halfback	☐	Five Eighth	☐
Centre	☐	Wing	☐
Full Back	☐	Interchange	☐
Not Playing	☐		

If not playing, please provide details ____

____

____

____

Did you have possession of the ball at the time of injury Y ☐ N ☐

At the time of your injury, which team had possession of the ball?

☐ Your Team ☐ The Opposition Team
☐ Neither Team

Was a penalty called at the time of your injury? Y ☐ N ☐

If Yes, was the penalty awarded against…

☐ You ☐ The Opposition Player
☐ Both Players ☐ The Opposition Team

What is your estimated absence from playing due to your injury?

☐ No Absence ☐ One – Three Weeks
☐ Less Than One Week ☐ More Than Three Weeks

Disclosure Statement and Privacy Consent

SLE Worldwide Australia Pty Limited (SLE) is committed to protecting the privacy of the personal information you provide to us.

We will use the personal information requested on this form to enable us to consider your claim. We may also need to collect additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if your claim is investigated by us.

If you do not provide us with this information, we may not be able to process your claim.

- We may disclose your personal information we collect on this form and any other additional information we collect in relation to this claim:
- to our relevant staff and contractors involved in delivering our services;
- if a broker collects the claim form from you, to that broker (this is applicable to the claim from only);
- to your employer;
- to your sports association to confirm your eligibility to claim under a policy arranged by it;
- to the insurer, Underwritten for certain underwriters at Lloyds of London by their agent SLE Worldwide Australia Pty Limited;
- to reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- to facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- to consultant doctors and physicians (in connection with the handling of your claim);
- to claims investigators and surveillance officers (in circumstances where the claim is investigated by us);
- if required to do so by a law enforcement body or by law; and

  You may request access to your personal information we hold about you and where necessary, correct any errors in this information (some restrictions and costs may apply).

By completing and returning this form and agreeing to us collecting additional information from the parties specified above in connection with your claim, you agree to us using and disclosing your information as set out above.

This consent to the use and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice.

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold about you is accurate, complete and up-to-date.

I agree that a photostat copy of this document shall be considered as effective and valid as the original and specifically authorised its use as such.

Name (please print): ____

Signature ______________________________ Date: ______/ ______/ ______

Electronic Banking Details to be completed by the insured person

Please Provide Account Details to ensure prompt payment of your benefits.

Name of Bank / Credit Union / Building Society, etc:

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Branch: ____

Account in the Name of: ______________________________________

Type of Account: ____

BSB Number: ____

Account Number: ____

I / We, (please print) ____

declare and warrant that the above particulars are true and correct in every detail.

Further, I / We authorise SLE Worldwide Australia Limited to credit this Account with any monies payable to me under the Policy of Insurance.

I shall notify Arthur J. Gallagher of any changes to the above details Immediately in writing.

Please note ONLY an original document will be accepted (a photocopy will NOT be accepted).

Name (please print): ____

Signature ______________________________ Date: ______/ ______/ ______

Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

Non Medicare medical expenses claim

1. Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

Loss of income claim (if eligible)

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

Important

1. Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete
2. Please forward your completed Sports Injury Claim Form to our office within 30 days of your injury. Do no wait for all your medical accounts. Forward them to us as you receive them.
3. Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.
4. If you have any questions or problems please contact us, we are always ready to help.

Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for Arthur J. Gallagher. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer your complaint to the Insurance Broking Division of the Financial Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the Arthur J. Gallagher web site at www.ajg.au or telephone 1800 240 432.

Claims Handling

Claims are processed at Arthur J. Gallagher Brisbane office (refer Brisbane address below). To maximize claims handling efficiency send your completed claim form and documentation direct to that office.

Arthur J. Gallagher City Offices

Adelaide
168 Greenhill Road
Parkside, SA 5063
T: 08 8172 8000
F: 08 8172 8100
adelaide@ajg.com.au

Brisbane
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Toowong Qld 4066
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F: 07 3367 5100
brisbane@ajg.com.au

Canberra
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