V-INSURANCE GROUP
CORPORATE AUTHORISED REPRESENTATIVE OF Willis

**Office use only**
**Policy Number:**_____
**Claim Number:**_____.

NETBALL VICTORIA

# PERSONAL INJURY CLAIM FORM


INSURANCE BROKER
FOR NETBALL VIC

V-Insurance Group Pty Ltd

Authorised Representative No. 432898
an authorised representative of
Willis Australia Limited AFSL: 240600
Level 25, 123 Pitt Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547
Fax (02) 8599 8661
Email: netball@vinsurancegroup.com


**CLAIM FORMS ARE TO BE SENT TO**

**Fullerton Health Corporate Services**
**Level 10, 33 York Street**
**SYDNEY NSW 2000**
**Phone: (02) 8256 1770**
**Fax: (02) 8256 1775**
**Email: claims@fullertonhealthcs.com.au**

# NETBALL VIC
# SUMMARY OF INSURANCE COVER

## What is Covered?

The Netball Australia National Risk Protection Insurance Personal Accident Insurance Program, which extends to cover Netball VIC provides cover for a number of policy benefits. Please refer to the V-Insurance Group Netball Australia website to view the Product Disclosure Statement with full terms and conditions.

The most commonly claimed sections of the Netball VIC Personal Accident policy are reimbursement of Non Medicare Medical expenses and Loss of Income cover.

**Important information**

The Health Insurance Act (Cth) 1973 does not permit the insurer to contribute to any charges covered, or partially covered by Medicare. Sometimes, your Doctor, specialist or surgeon may charge more than the Medicare rebate, which may leave you with out of pocket expenses. This is commonly called the "Medicare Gap". The Medicare Gap is not covered by the Netball VIC Insurance Program due to Government Legislation.

Please refer to the table below for some common examples:

| **Non-Medicare Medical Items; claimable as per the Personal Accident policy wording** | **Items covered by Medicare; not claimable through the Personal Accident Policy** |
|---|---|
| **Ambulance** | Doctor |
| **Physiotherapist** | Public Hospitals |
| **Dental** | Surgeon & Surgeon's Assistant |
| **Private Hospital Accommodation** | X-Rays |
| **Chiropractor** | Anaesthetist |
| **MRI Scans*** | MRI Scans* |
| ***MRI scans are generally covered through Medicare; however please check with your treating physician, as sometimes the provider is not registered with Medicare.** | |

## What are the Policy Benefits for Non Medicare Medical and Loss of Income

The following table outlines the policy benefits applicable for Non Medicare Medical and Loss of Income under the Netball VIC Insurance Program;

| **Non-Medicare Medical** | **Benefit** |
|---|---|
| If you have Private Health Insurance | Reimbursement of 100% up to $2,500 per injury for members / players ($5,000 for officials and volunteers)<br>$Nil excess |
| If you do not have Private Health Insurance | Reimbursement of 80% up to $2,500 per injury for members / players ($5,000 for officials and volunteers)<br>100% cover for ambulance only up to $2,500 for members / players and $5,000 for officials and volunteers<br>$75 excess |
| **Loss of Income** | **Benefit** |
| If as a result of your injury you are prevented from working in your occupation a Loss of Income benefit may apply | 100% reimbursement or<br>$250 per week (members / players). Higher limits apply for officials / volunteers<br>14 day excess, 104 week benefit period |

## Important Notes

This insurance cover is underwritten by:- QBE Insurance (Australia) Limited
ABN 78 003 191 035

1. This summary of cover provides factual information about the Netball VIC Insurance Program.
2. This information is only a summary of the cover provided. The policy with full conditions is available at www.vinsurancegroup.com/netballaustralia or available by contacting Netball VIC.
3. This insurance program commences on 1 February 2017 and expires on 1 February 2018.
4. V Insurance facilitates this insurance program which provides benefits to those registered members of Netball VIC who, through injury or accident, incur financial loss and who would otherwise not have 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. Netball VIC is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

# HOW TO MAKE A CLAIM

Dear Netball VIC 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 5 & 6 and sign and date the Declaration.

**3.** Please ensure that your Association/Club official completes and signs the Association/Club Declaration on page 5.

**4.** For claims involving Loss of Income:

a) You must complete page 8 and have your employer/salary officer to complete page 8. If self employed, you must have your accountant complete these details;

b) Have your Attending Physician or Physiotherapist complete the page titled “Doctor’s Statement” on page 10.

**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 10.

**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 the insurer 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 bed 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 fully completed all sections of the claim form, please have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.

8. Once you have completed your claim form, please forward to Fullerton Health Corporate Services (FHCS). They handle all claims for the insurer. Their contact details are as follows;

**Fullerton Health Corporate Services**
**Level 10, 33 York Street**
**SYDNEY NSW 2000**
**Phone: (02) 8256 1770**
**Fax: (02) 8256 1775**
**Email: claims@fullertonhealthcs.com.au**

9. Your reimbursement cheques will be sent to you directly by Fullerton Health Corporate Services.

10. Once your claim is registered, you can submit ongoing invoices via Fullerton Health Corporate Services. Fullerton Health Corporate Services (Claims Services) can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

11. 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

| | | |
|---|---|---|
| Association Name(compulsory):<br><br>Club Name: | Member No (if applicable): | Claimants Given Name:<br><br>Surname: |
| Name of team/age group/grade: | | |
| Gender (please tick):<br>☐ Male ☐ Female | Occupation: | Date of Birth: / / |
| Address State Postcode | | Email: |
| Phone Number (work):<br>( ) | Home:<br>( ) | Mobile: |

Please tick the category applicable ☐ Player ☐ Official ☐ Coach ☐ Umpire ☐ Other

If Other, please advise _____

## DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

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 QBE Insurance (Australia) Limited 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, medical 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 QBE Insurance (Australia) Limited and their service providers in order to assess the claim. QBE Insurance (Australia) Limited 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 _____ Date_____

(or Legal Guardian if under 18 years of age)

## DECLARATION BY ASSOCIATION/CLUB

| | |
|---|---|
| Name of Association/Club: | Name of Association/Club Official making this statement: |
| Official Position: | Telephone Number: ( )<br><br>Email: |
| Address State Postcode | |

I, the above mentioned Netball VIC Club Official, confirm that the claimant was a registered and Financial member of this Netball VIC club and was an insured person as identified in the Personal Accident Insurance with QBE Insurance (Australia) Limited at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge 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 below

_____

| | |
|---|---|
| Dated: / / | Signature of Association/Club Official: |

**Office use only**
**Policy Number:**
**Claim Number:_____.**

## ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury?

When did your accident occur?
Date: / / Time: am/pm

| | | |
|---|---|---|
| Was your activity at the time of the accident? (please tick) | Officially organised competition | ( ) |
| | Officially organised training | ( ) |
| | Social or private competition | ( ) |
| | Travelling to and from activity | ( ) |
| | Sanctioned fundraising/social event | ( ) |
| What type of Netball activity were you participating in? (please tick) | Netball Association / Club Activity | ( ) |
| | Fast 5 Netball | ( ) |
| | NetFest | ( ) |
| | Rock Up Netball | ( ) |

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 reported? | Date and time reported?<br>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? Yes/No | If yes, please advise when? / / |

| **The following information is required for Netball VIC research to assist with Risk Management, <u>answering these questions will not affect your claim</u>** | | |
|---|---|---|
| Where did your injury occur? (please tick) | Indoor | ( ) |
| | Outdoor | ( ) |
| Surface at point of injury? (please tick) | Timber | ( ) |
| | 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…… | ( ) |
| Quarter/half injured? (please tick) | 1st Quarter | ( ) |
| | 2nd Quarter | ( ) |
| | 3rd Quarter | ( ) |
| | 4th Quarter | ( ) |
| | Not applicable | ( ) |

## LOSS OF INCOME

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

| | (please tick the box) Yes | No |
|---|---|---|
| 1. Can compensation be claimed under worker's compensation or any other insurance or any other insurance including Loss of Income? | | |
| 2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance? | | |
| 3. Have you engaged in any other income earning employment since you have been injured? | | |

**THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER/SALARY OFFICER. IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT 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:<br>Net $..... Gross $.....<br>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:<br>/ / |

Income Definition:

☐ Self Employed ☐ Full Time ☐ Part Time ☐ Casual

During the period of incapacity the employee has received

| | | | | | |
|---|---|---|---|---|---|
| $..... | Normal Pay | From | ……/……/…… | to | ……/……/…… |
| $..... | Sick Pay | From | ……/……/…… | to | ……/……/…… |
| $..... | Workers' Compensation | From | ……/……/…… | to | ……/……/…… |
| $..... | Other (please specify) | From | ……/……/…… | to | ……/……/…… |

Has the employee returned to work? ☐ Yes ☐ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ☐ Yes ☐ No

## A. IF EMPLOYED

| | |
|---|---|
| Salary officers name: | Phone Number: ( ) |
| Salary officers signature:<br><br>Company Stamp: | Date: / /<br><br>ABN/ACN: |

## B. IF SELF EMPLOYED

| | |
|---|---|
| Accountant's name: | Phone Number: ( ) |
| Accountant's signature:<br><br>Accountants Company Stamp: | Date: / / |

## NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

Are you a member of an Ambulance Service? ☐ Yes ☐ No

Are you a member of a Private Health Fund? ☐ Yes ☐ No

If yes, please provide details .....

Hospital Cover? ☐ Yes ☐ No

Extra's covering, Physio etc ☐ Yes ☐ No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

| NAME OF PROVIDER | NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC | DATE OF SERVICE | CHARGE | PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE) | AMOUNT CLAIMABLE |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | **Total** | |
| | | | | **Less Excess** | |
| | | | | **TOTAL AMOUNT OF CLAIM** | |

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor:.....

Address:.....

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CORPORATE AUTHORISED REPRESENTATIVE OF WILLIS
Authorised Representative No. 432898
an authorised representative of
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Phone (02) 8599 8660
or local call cost only 1300 945 547
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# SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

**IMPORTANT**

1. **The patient is responsible for any fee for this statement.**
2. **This form can only 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/PHYSIOTHERAPIST

| Patient's Full Name: | How long have you known the patient? |
|---|---|

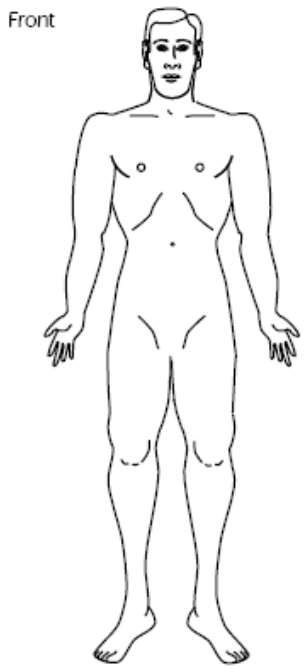
What date and where were you first consulted by the patient in connection with the present injury? / /

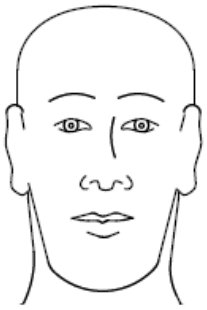
Patient's Occupation:

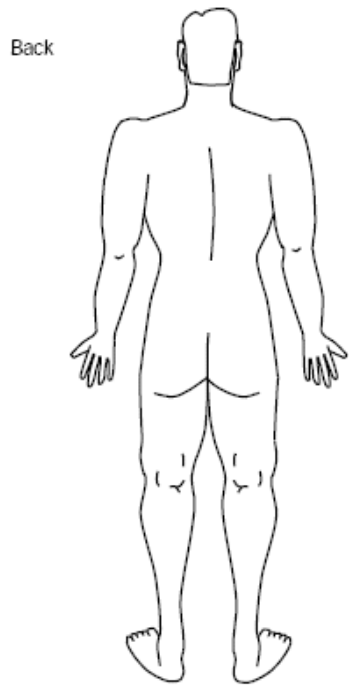
Are you the patient's regular general practitioner? ☐ Yes ☐ No

If not, please advise who is .....

What is the exact nature of the present injury?



Do you consider the patients 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 treatment? ☐ Yes ☐ No

Please specify the type and approximate number of treatments required:

☐ 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 assessing this condition? .....

.....

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? ☐ 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 netball?

Does the patient have any congenital defects or chronic diseases? ☐ Yes ☐ No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

## CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

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) ☐ Cheque ☐ EFT

If you would like your payment made by EFT, please complete the details below.

## NAME OF CLAIMANT

Title: ☐ Mr. ☐ Mrs ☐ Miss

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 BY CLAIMANT (OR GUARDIAN IF CLAIMANT UNDER 18)

I hereby authorise Fullerton Health Corporate Services (FHCS) as agents of QBE Insurance (Australia) Limited 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 FHCS has instructed its bank to credit the nominated account and that we release FHCS from any further liability in relation to this payment.
- FHCS 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 FHCS collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to FHCS (Claims Services)'s disclosure of this information, to FHCS's 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 *Privacy Act 1988.* 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 Netball Australia's insurance brokers, V-Insurance Group.

Signature: _____ Date: _____

Print Name: _____