Sports Underwriting Australia
Sports Injury Claim Form

Sports Underwriting Australia Claims Department
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IMPORTANT NOTICES

Your Duty of Disclosure

This Policy is subject to the Insurance Contracts Act 1984 (Act). Under that Act you have a Duty of Disclosure.

Before you take out insurance with us, you have a duty to tell us of everything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms. If you are not sure whether something is relevant you should inform us anyway.

You have the same duty to inform us of those matters before you renew, extend, vary, or reinstate your contract of insurance. The duty applies until the Policy is entered into, or where relevant, renewed, extended, varied or reinstated (Relevant Time). If anything changes between the time the answers are provided to us or disclosures are made and the Relevant Time, you need to tell us.

Your duty however does not require disclosure of matters that:

- reduce the risk;
- are common knowledge;
- we know or, in the ordinary course of our business, ought to know, or
- we have indicated we do not want to know.

If you do not comply with your duty of disclosure, we may be entitled to:

- reduce our liability for any claim;
- cancel the contract;
- refuse to pay the claim, or

avoid the contract from its beginning, if your nondisclosure was fraudulent.

Who Needs To Tell Us

It is important that you understand that you are answering our questions in this way for you and anyone else whom you want to be covered by the Policy.

Dispute Resolution Process

If you are not satisfied with our service please tell us so we can help. We will address complaints in accordance with Great Lakes Australia's Complaints Handling Process and the Insurance Council of Australia's Code of Practice.

If you have a complaint:

Step 1: Contact us

You can contact us by:

Postal Address: PO Box 288, Kew East
Victoria. Australia 3102
Tel: +61 3 8862 2600
Email: info@sportsunderwriting.com.au

If we require additional information we will contact you to discuss. If your complaint is not immediately resolved we will respond within 15 business days of receipt of your complaint or agree on a reasonable alternative timetable with you.

Step 2: Internal Dispute Resolution

If you are not satisfied with our response you may refer it in writing to our Internal Dispute Resolution panel, which is independent of the original complaint review.

E-mail: disputes@gla.com.au
Postal Address: Attn: Dispute Resolution Officer
Great Lakes Australia PO Box H35 Australia Square NSW 1215

The panel will respond within 15 business days. If the panel cannot respond within 15 business days, the panel will agree a reasonable alternative timetable with you. If the panel cannot reach an agreement on an alternative timetable, the panel will advise you of your right to take your complaint to the FOS.

Step 3: External Dispute Resolution scheme

If we are unable to resolve your complaint within 45 days of the date we first received your complaint or if you remain unsatisfied, you can seek a free review by the FOS. The FOS is an independent national body and we agree to accept its decision.

You can contact the FOS by:

Postal Address: Financial Ombudsman Services Australia Ltd, GPO Box 3, Melbourne VIC 3001
Tel: 1800 367 287
Email: info@fos.org.au
Website: www.fos.org.au

Privacy Statement

In this Privacy section "we", "us" or "our" means Great Lakes Australia and Sports Underwriting Australia, unless specified otherwise.

We are committed to the safe and careful use of your personal information in the manner required by the Privacy Act 1988 (Cth) and the Australian Privacy Principles.

We collect your personal information in order to assess your application for insurance and, if your application is accepted, to administer and manage your Policy and respond to any claim that You make. To do this, your personal information may need to be disclosed to reinsurers and service providers and related entities who carry out activities on our behalf, such as assessors and facilitators, some of whom may be located in overseas countries. Our contractual arrangements generally include an obligation for these reinsurers, service providers and related entities to comply with Australian privacy laws.

By providing us with your personal information, you consent to the disclosure of your personal information to reinsurers, service providers and related entities in overseas countries to enable us to assess your application, to administer and manage your Policy and to respond to any claim that you make. If you consent to the disclosure of your personal information to overseas recipients, and the overseas recipient handles your personal information in a way other than in accordance with the Australian privacy laws, we may not be responsible for the handling of your personal information by the overseas recipient.

If you choose not to provide your personal information and/or choose not to consent and / or withdraw your consent to the disclosure of your personal information at any stage, we may not be able to assess your application or administer and manage your insurance policy and respond to any claim that you make.

Our Privacy policies contain information on how you may access personal information that each of us hold, or seek correction of Your personal information and information on how to make a complaint about the handling of your personal information and how complaints are handled. If you require more information, you can access the Great Lakes Australia Privacy Statement at www.munichre.com/io/gla/en/privacy_statement.aspx and SUA Privacy Policy and Privacy Statement at www.sportsunderwriting.com.au/documents.html.

Taxation Information

The amount of cover available under this Policy excludes Goods and Services Tax (GST).

If you are not registered for GST, in the event of a claim we will reimburse you the GST component in addition to the amount that we pay.

The amount that we are liable to pay under this Policy will be reduced by the amount of any input tax credit that you are or may be entitled to claim for the supply of goods or services covered by that payment.

If you are entitled to an input tax credit for the Premium you must inform us of the extent of that entitlement at or before the time you make a claim under this Policy. We will not indemnify you for any GST liability, fines or penalties that arise from or are attributable to your failure to notify us of your entitlement (or correct entitlement) to an input tax credit on the Premium.

If you are liable to pay an Excess under this Policy, the amount payable will be calculated after deduction of any input tax credit that you are or may be entitled to claim on payment of the Excess.

If you are unsure about the taxation implications of this Policy, you should seek advice from your accountant or tax professional.

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:	Membership Number:	Period/Expiry of Membership

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:		Please describe how the injury occurred	
Address where you were injured:			

Date of Injury:		Time:		Training:	Yes ☐	No ☐	Playing:	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:	

Advise when you did (or expect to):

Cease work/normal activities _____
Cease training _____
Cease participating _____
Resume work/normal activities _____
Resume training _____
Resume participating _____

To be completed by the Club Official / Secretary / Treasurer.
Please ensure that all questions have been fully answered.

Name of Member				was injured as stated.	
Type of Member					
Name of Club					
Official Name		Official Position		Telephone	
Address of Club / Association				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	

Details of Non Medicare expenses claimed.

NB: It should be noted that the policy does not provide cover any services that are subject to a Medicare Rebate as the Health Insurance Act (1984) does not permit us to contribute to any charges covered by Medicare, including the Medicare Gap. This includes surgery costs, surgeon's fees, anaesthetist's fees, doctor's fees, x-rays and ultrasounds.

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 ☐

Ambulance Cover 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

(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: 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 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: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountants Company Stamp:	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.

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Declaration

I declare that, to the best of my knowledge and belief, the information in this form is true and correct and I understand the claim may be refused or reduced if information is withheld.

I understand that I may have to provide relevant documentation to enable complete consideration of my claim.

I consent to Great Lakes Australia and Sports Underwriting using the personal information I have provided on this form for the purposes of processing my claim. I consent to the disclosure of sensitive information to third parties in order to process my claim. I consent to the disclosure of any personal information (including sensitive information) overseas where it is reasonably necessary for the processing of my insurance claim. I understand that if this consent is not given Great Lakes Australia and Sports Underwriting will not be able to process this insurance claim.

Signature of insured or person with authority to sign for and on behalf of a company or partnership.

Signature: _____ Date: ___/___/_____

Please indicate the number of additional pages attached to this claim form: _____

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:

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

Has the patient finished all treatment, if yes what date?		If no, what is your estimated treatment time frame	
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:
Position:		
Signature:	Degree:	Date: