



**V-INSURANCE  
GROUP**

CORPORATE AUTHORISED REPRESENTATIVE OF WILLIS

Office use only

Policy Number: ATHL01STI-LY0411

Claim Number: \_\_\_\_\_



# ***Athletics Australia***

## **PERSONAL INJURY CLAIM FORM**

### **INSURANCE BROKER FOR ATHLETICS AUSTRALIA**

V-Insurance Group Pty Ltd  
Authorised Representative No. 432898  
an authorised representative of  
Willis Australia Limited AFSL: 240600  
Level 4, 179 Elizabeth Street, SYDNEY NSW 2000  
Phone (02) 8599 8660 or local call cost only 1300 945 547  
Fax (02) 8599 8661  
Email: [sports@vinsurancegroup.com](mailto:sports@vinsurancegroup.com)

### **CLAIM FORMS ARE TO BE SENT TO:**

**Corporate Services Network (CSN)**

**Level 2, 280 George Street  
SYDNEY NSW 2000**

**Phone: (02) 8256 1770  
Fax: (02) 8256 1775  
Email: [claims@csnet.com.au](mailto:claims@csnet.com.au)**

# ATHLETICS 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 \$100,000 (other than anyone under 18 years and over 65 years to 100 years \$20,000 maximum). The paraplegia and quadriplegia benefit is \$250,000.

### Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$2,500. Claimable expenses are private hospital bed fee and theatre fees, ambulance, dental, Physiotherapy etc, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or \$50 for claimants who do not have private health insurance. Cover is limited to expenses incurred within 52 weeks from the date of injury.

### Student Tutorial Benefit (Full time students)

Reimburses 100% of actual expenses up to \$500 per week for up to fifty two (52) weeks incurred for home tutorial services by a qualified tutor to assist the full-time student – 7 day excess.

### Household Help Allowance

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of \$500 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

Up to \$50 per day to a maximum of \$3,000 for reasonable costs incurred by the parents of an insured person who is hospitalised.

### Loss of Income

Cover for 80% of your weekly salary or up to a maximum of \$700 per week, whichever is the lesser. The benefit period is 52 weeks and the excess is 7 days.

### Important Notes

Savannah Insurance Agency Pty Ltd  
On and behalf of Certain underwriters at Lloyds of London  
ABN 84 130 364 313  
GPO Box 4920, Sydney NSW, 2001

This summary of insurance cover provides factual information about the Athletics Australia Insurance Program as contained in the Product Disclosure Statement (PDS). Cover is subject to the full terms, conditions and exclusions contained in the PDS. Certain terms used in this summary are defined in the PDS.

The policy with full terms, conditions and exclusions is available at [www.willis.com.au/athleticsaustralia](http://www.willis.com.au/athleticsaustralia) or by contacting Athletics Australia.

This insurance program commences on 1 April 2014 and expires on 1 April 2015.

V Insurance facilitates this insurance program which provides benefits to those registered members of Athletics Australia 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.

Athletics Australia is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

**Further details on the Athletics Australia insurance program can be obtained by visiting**  
[www.willis.com.au/athleticsaustralia](http://www.willis.com.au/athleticsaustralia)

# HOW TO MAKE A CLAIM

Dear Athletics 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, 6, 9, 10, 14 and sign and date the Declarations on pages 9, 10, 14.
3. Please ensure that your Club official completes and signs the Club Declaration on page 4.
4. For claims involving Loss of Income:  
You must complete page 7 and have your employer/salary officer to complete page 7. If self-employed, you must have your accountant complete these details;  
Have your Attending Physician complete the page titled "Attending Physician's Report" on page 11 and sign the declaration on page 12.
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).  
Have your Attending Physician complete the "Attending Physician Report" on pages 11&12.
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:**

7. No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. Government legislation including The Private Health Insurance Act 2007 (Cth) does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).
8. The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for Non-Medicare Medical items such as but not limited to private hospital (for accommodation and theatre fees only), ambulance (if not otherwise covered), physiotherapy, nurse, as prescribed by a surgeon to aid recovery.
9. 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.
10. Once you completed all sections of the claim form, please have your Club and State Association complete and sign page 4 confirming that your injury occurred during sanctioned activity.
11. Once you have completed your claim form, please forward to Corporate Services Network with all relating documentation and receipts. They handle all claims for the insurer. Their contact details are as follows;

**Corporate Services Network  
Level 2, 280 George Street  
SYDNEY NSW 2000  
Phone: (02) 8256 1770  
Fax: (02) 8256 1775  
Email: [claims@csnet.com.au](mailto:claims@csnet.com.au)**

12. Your reimbursement cheques will be sent to you directly from Corporate Services Network.
13. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim,
14. 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

Claimants Given Name: Surname:	Member No (if applicable):	Club Name:
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth: ___/___/___
Address	State      Postcode	Email:
Phone Number (work): (    )	Home (    )	Mobile
Please tick the category applicable: <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Volunteer <input type="checkbox"/> Other		
If Other, please advise _____		

## DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: (    )
Address	State      Postcode

I, the above mentioned Athletics Australia Club Official, confirm that the claimant was a registered and Financial member of this Athletics Australia club and was an insured person as identified in the Personal Accident Insurance with Savannah Insurance Agency for and on behalf of Lloyds of London 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.

Signature of Club Official:	Dated: ___/___/___
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## STATEMENT BY ATHLETICS AUSTRALIA STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered member of the Athletics Australia Personal Accident Insurance Program. Where the injury occurred during an event, I confirm the event was officially sanctioned by Athletics Australia.

Name of State/Territory:	Name of State/Territory:
Signature of Association Official:	Signature of Association Official:

## ACCIDENT DETAILS

Describe the accident and how it happened? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe your injury?

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

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?

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

Resume work/normal activities \_\_\_\_\_

Cease training

Resume training \_\_\_\_\_

Cease participating

Resume participating \_\_\_\_\_

Have you ever had this injury or similar injuries in the past?

If yes, please advise when?

/ /

Which Athletics Australia activity were you participating in at the time of your accident? (please tick)

- Walking  
 Running  
 Throwing  
 Jumping  
 Other (please advise \_\_\_\_\_)

Please tick the category applicable (please tick)

- Athlete  
 Official  
 Coach  
 Other e.g. Volunteer (please advise \_\_\_\_\_)

- 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

**The following information is required for Athletics 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 | ( ) |
|   | Running Track               | ( ) |
|   | Other, please advise.....   | ( ) |

- |                                   |              |     |
|-----------------------------------|--------------|-----|
| Weather conditions? (please tick) | Fine         | ( ) |
|                                   | Rain         | ( ) |
|                                   | Showers      | ( ) |
|                                   | Extreme Heat | ( ) |
|                                   | Extreme Cold | ( ) |

- |   |            |     |
|---|------------|-----|
| What were you doing when the accident occurred? | Running    | ( ) |
|   | Warming Up | ( ) |
|   | Walking    | ( ) |
|   | Throwing   | ( ) |
|   | Jumping    | ( ) |
|   | Other      | ( ) |

## 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:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Company Stamp:

ABN/ACN:

### B. IF SELF EMPLOYED

Accountant's name:

Phone Number: ( )

Accountant's signature:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Accountants Company Stamp:





## 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  Other

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 Corporate Services Network (CSN) as agents of Savannah Insurance Agency for and on behalf of Lloyds of London 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 CSN has instructed its bank to credit the nominated account and that we release CSN from any further liability in relation to this payment.

CSN 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 CSN collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to CSN's disclosure of this information, to CSN'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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

## TO BE COMPLETED BY THE CLAIMANT

### Privacy Statement

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at [www.csnet.com.au](http://www.csnet.com.au) and send to [privacy@csnet.com.au](mailto:privacy@csnet.com.au)

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

### Medical Authority And Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information pursuant to CSN's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

<b>Signature of Claimant:</b>		<b>Dated:</b>	
<b>Name of Claimant</b>			
<b>Signature of Witness:</b>		<b>Dated:</b>	
<b>Name of Witness:</b>			

# V-INSURANCE GROUP

Authorised Representative No. 432898  
an authorised representative of  
Willis Australia Limited AFSL: 240600  
Level 4, 179 Elizabeth Street, SYDNEY NSW 2000  
Phone (02) 8599 8660 or local call cost only 1300 945 547  
Fax (02) 8599 8661  
Email: [sports@vinsurancegroup.com](mailto:sports@vinsurancegroup.com)

Office use only  
Policy Number: **ATHL01STI-LY0411**  
Claim Number: \_\_\_\_\_

## SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

### IMPORTANT

The patient is responsible for any fee for this statement.

This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.

If "Yes" answered to any of the following, please give details.

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? \_\_\_\_\_

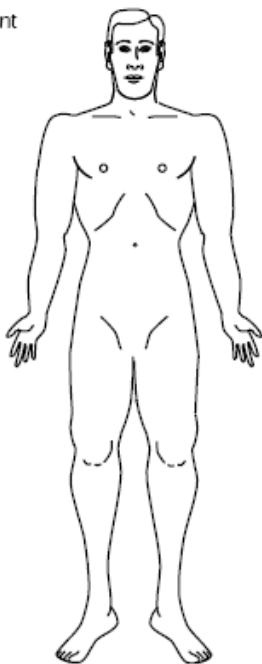
What date and where were you first consulted by the patient in connection with the present injury?     /     /

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

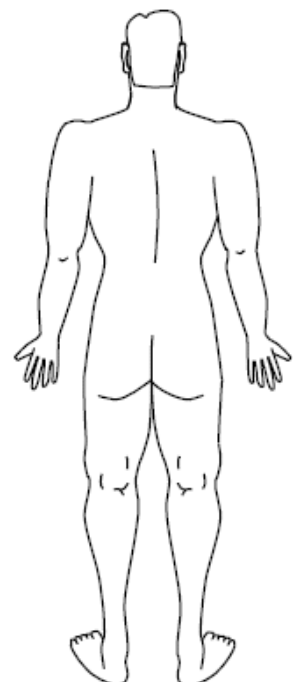
If not, please advise who is \_\_\_\_\_

What is the exact nature of the present injury? \_\_\_\_\_  
\_\_\_\_\_

Front



Back



Head





## WHAT TO DO

Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.

Send this form to:

Corporate Services Network  
Level 2, 280 George Street, Sydney NSW 2000, or  
Fax 61 2 8256 1775 or  
[claims@csnet.com.au](mailto:claims@csnet.com.au)

## DISPUTE RESOLUTION & COMPLAINTS PROCESSES

Savannah has established formal internal dispute procedures to ensure that all enquiries and complaints are fairly and properly considered and dealt with. If You have an enquiry or complaint about Our services or the services of Savannah please phone Our Complaints Manager on (02) 8234 0416.

If Your complaint remains unresolved, please contact:

Savannah Dispute Resolution Manager	Telephone:	(02) 8234 0416
GPO Box 4920, Sydney NSW 2001	Facsimile:	(02) 8078 0162
Email: <a href="mailto:feedback@savannahgroup.com.au">feedback@savannahgroup.com.au</a>		

If You are unhappy with Savannah's response, or Savannah has taken more than fifteen (15) working days to respond, You should contact the Compliance Officer at:

Lloyd's Australia Limited	Telephone:	(02) 9223 1433
Suite 2, Level 21 Angel Place	Facsimile:	(02) 9223 1466
123 Pitt Street, Sydney NSW 2000	Email:	<a href="mailto:ldraustralia@lloyds.com">ldraustralia@lloyds.com</a>

If You are not satisfied with the outcome of either Savannah or Lloyd's Australia Limited's dispute resolution process You may lodge a written complaint with the Financial Ombudsman Service Limited (FOS) which can be contacted at:

GPO Box 3, Melbourne VIC 3001  
Freecall: 1300 78 08 08  
Fax: (03) 9613 6399  
Email: [info@fos.org.au](mailto:info@fos.org.au)  
Web: [www.fos.org.au](http://www.fos.org.au)

This service is offered to You free of charge and their decisions are binding on Savannah but not You.

## SAVANNAH PRIVACY

We are committed to protecting the privacy of Your personal information in accordance with the terms of the *Privacy Act* 1988 (Cth). We collect and Use the personal information You provide Us to quote on Your application for a Policy, to provide the insurance, administer the Policy and assess and manage any claims. In some circumstances, We may collect Your personal information from someone other than You, such as when we require third party information to assess a claim; however We will only do so when We are unable to collect it directly from You.

We may need to disclose your personal information to our related companies, business partners and service providers, including our Lloyd's underwriters and their reinsurers, which assist us to provide insurance and process claims. In some circumstance, these third parties are located outside Australia. As such, we are likely to disclose your personal information to recipients overseas, situated in the United Kingdom.

If You do not provide Us with full information, We cannot properly quote for Your insurance and We cannot insure You. You can seek access to, and the correction of, the personal information We hold about You at any time. Such applications should be directed to Savannah, in writing, where it will be considered by its internal privacy

disputes department. Details of how to submit an application are set out in our Privacy Policy, which You can view at [www.savannahgroup.com.au/emailprivacy.php](http://www.savannahgroup.com.au/emailprivacy.php). Also in our Privacy Policy is information on how You can make a complaint about the way in which we handle your personal information, and how we will deal with any complaint.

If You provide Us with personal information about anyone else, We rely on You to have obtained their consent and to have informed them of the matters set out in this clause.

If the information is sensitive, We rely on You to have obtained their consent on these matters. For more information about Our approach to privacy, please visit Our Website for a copy of our Privacy Policy, or contact our Privacy Officer on

Savannah Privacy Officer  
GPO Box 4920, Sydney, NSW 2001  
Telephone: (02) 8234 0416  
Facsimile: (02) 8078 0162

Declaration:

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/We have read and understood the Privacy Act 1998 information and Medical Authority referred to above and consent to the collection, storage and use and disclosure of my/our personal sensitive information. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Savannah Insurance Agency Pty Ltd will be unable to process my/our claim.

Please circle Claimant / Parent / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

Please note we are unable to process any claim without a signed declaration.

Declaration:

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/We have read and understood the Privacy Act 1998 information and Medical Authority referred to above and consent to the collection, storage and use and disclosure of my/our personal sensitive information. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then IICH will be unable to process my/our claim.

Please circle Claimant / Parent / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

Savannah Insurance Agency  
GPO Box 4920, Sydney NSW 2001  
Email: [enquiries@savannahgroup.com.au](mailto:enquiries@savannahgroup.com.au)

Telephone: (02) 8234 0416  
Facsimile: (02) 8078 0162