PERSONAL INJURY

INSURANCE

CLAIM FORM

Basketball NT

Dear Basketball 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 will delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted within 30 days from the date of your injury occurring. Please do not wait until after you have completed treatment for your injury to lodge your claim form.

2. Please ensure that you fully complete Page 3.
3. Please ensure that an Association Official completes and signs the Association Declaration in Section B.
4. For claims involving medical expenses:-

   Please have your General Practitioner, Surgeon, Specialist or Dentist complete Section G
   Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, surgeon, specialist or dentist). The claim form will not be accepted if completed by a Physiotherapist, Chiropractor etc.)

5. For claims involving Loss of Income you must:-
   a) Arrange for your employer/salary officer to complete Section F. If self employed, you must have your accountant complete these details;
   b) Have your General Practitioner, Surgeon, Specialist or Dentist complete the Section G and the attached "Incapacity to Work Statement". It will not be accepted if completed by a Physiotherapist, Chiropractor etc.)
   c) You must please provide four of your recent payslips showing your earnings.

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 Health Insurance Act 1973 does not permit Insurers 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, 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. Please keep a copy of the claim form as well as the receipts for your safe keeping.

8. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to

   PSC Horsell Claims Solutions
   PO Box N661
   Grosvenor Place
   SYDNEY NSW 1220

   PSC Horsell Claims Solutions will confirm receipt of your claim form within 10 to 15 working days. They will advise you of your claim number and where to send any ongoing medical receipts and other relating documentation.

9. If you have any further queries relating to your claim, benefits, excesses or special conditions/exclusions, please do not hesitate to contact the PSC Horsell Claims Solutions Team on:-

   Phone: (02) 1300 722 990
   Fax: (02) 9247 1733
   Email: basketballclaims@pschorsell.com
   Website: www.pscinsurancegroup.com

PERSONAL INJURY CLAIM FORM

(Every question MUST be fully answered, blanks are not acceptable). Please attach a separate sheet if there is not sufficient space.

SECTION A: PERSONAL DETAILS

Injured Person's Name _____

Postal Address _____

Contact Number Home ( ) _____ Work: ( ) _____ Mobile _____

Email Address: _____

Date of Birth _____

Occupation _____

Sex: Male/Female

INFORMATION AUTHORITY AND WARRANTY

I hereby authorise any hospital, physician or other person who has attended me or any employer, to furnish Sportscover Australia Pty Ltd and / or PSC Horsell Claim Solutions or their representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and information pertaining to employment history and income tax returns. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that If I have made, or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover there under in respect of past or future injuries or sickness shall be forfeited.

PRIVACY CONSENT

I consent to Sportscover and PSC Horsell Claims Solutions:-

a) Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. If we do not collect this information we may not be able to process.

b) Disclosing my personal information to related entities, their staff members located outside Australia, the insured, other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Insurance Enquiries & insurance agent or other intermediary, my employer or Insurance Enquiries & Complaints Ltd for the purposes of administrating my claim or providing a report.

I understand that a copy of Sportscover and PSC Horsell Claims Solutions privacy policy statements, including information about access, may be obtained by visiting their websites www.sportscover.com , www.pscinsurancegroup.com or contacting their offices 61 2 8833 5800 (Sportscover) and 61 2 9247 1700 (PSCHCS).

SIGNED_____ DATED: _____
(Claimant)

SECTION B: ASSOCIATION DETAILS

Name of the Association Registered with:

_____

Name of the Club:

_____

Name of the Team:

_____

Registration Number:

_____

STATEMENT BY ASSOCIATION **(To be completed by the Association not by the Player)**

I …… of …….
(Name of Association Official) (Name of Association)

hereby certify that ……sustained the injuries resulting in this claim on
(Name of Player)

……../……../…….. at ……..am/pm whilst playing / training for ……...

against ……..at …….
(Place of Game)

Signed: ……..…….. Dated: ……../……../……..

SECTION C: INCIDENT DETAILS

1. Describe the incident and how it happened: _____

_____

2. Describe the injury _____

_____

3. When did the incident occur? Date _____ Time _____ am/pm

4. Where did the incident occur? _____

5. Activity at time of incident

Officially Organised Competition	❑
Official Representative Competition	❑
Officially Organised Practice	❑
Social or Private Competition	❑
Social or Private Practice	❑

Other _____

6. Name and address of witness _____

7. Person to whom incident reported _____

8. Time and Date reported _____

9. Brief summary of treatment/action taken at the time of the incident _____

_____

10. Name and qualifications (if any) of person who gave treatment _____

11. Was hospitalisation required? _____

Name of hospital and dates visited _____

12. Advise when you did (or expect to):
    (a) cease work/normal activities _____
    (b) cease training _____
    (c) cease participating _____
    (d) resume work/normal activities _____
    (e) resume training _____

13. Have you ever had this Injury, or similar injury, in the past 5 years? Yes ❑ No ❑

If Yes, when ____/____/_____Treated By_____

14. Have you ever lodged a Personal Accident or Illness claim before? If Yes, please provide details:

_____

_____

Give names, addresses and telephone numbers of all persons who are or have treated you for this condition

Names: _____Address:_____Telephone:_____

SECTION D: NON MEDICARE MEDICAL EXPENSES

(Only complete this Section if claiming for these expenses)

Please do not attach accounts paid or part paid by Medicare. The Health Insurance Act 1973 does not permit PSC Horsell 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 of Health Fund & Member No:

_____

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 eg. Physiotherapy Dental etc	Date of Service	Total Bill	Benefit Paid by Private Health Fund	Gap (Private Health fund NOT Medicare)
				Total	$
				Less Excess	$
				TOTAL AMOUNT OF CLAIM	$

SECTION E: DIRECT DEBIT DETAILS – This section must be completed

If your claim is accepted we will transfer any reimbursement to you by direct debit. To assist the reimbursement process, please complete the following section with your direct debit details:

BSB: __ __ __ - __ __ __

Account number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Name: _____

SECTION F: LOSS OF INCOME (Only complete section if claiming Loss of Income)

1. What is your normal Net (after tax) weekly salary/income? (Please attach four of your current pay slips) $ _____
2. Can compensation or benefits be claimed under Worker's Compensation or any other insurance? (eg. Income Protection) Yes ☐ No ☐ (if Yes, give details) _____
3. Have you engaged in any other income earning employment since you became disabled? Yes ☐ No ☐ (if Yes, give details) _____

1. Employer's Statement – If Employed as a Wage Earner (to be completed by your Employer)

I hereby certify that _____ has been unable to attend their usual occupation with the Company as a result of an Injury suffered whilst __ _____ on ___ /_____ /____

The employee's last day at work was ____ / ___ /____

The employee is expected to/did resume duties on ____ / ___ /____

The employee's salary at the date of injury was $ _____p/w (Net of tax)

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 ___ / ___ / ___

The employee has been employed with the company since ____ / ____ / ____

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

Name of Company _____

Address _____

Signature of Supervisor or Paymaster _____

Name of Supervisor or Paymaster (please print) _____

Telephone number _____ Date ____ / ____/_____

2. Accountant's Statement – Self Employed Persons Only (To be completed by your Accountant)

I _____ Manager/Accountant/Director/Partner of _____ of
(Name of Firm)

_____
(Address)

confirm that our firm act as Accountants for _____ of
(The claimant)

_____
(Name of Claimant's firm and address)

and his/her Net earnings (after tax and expenses) for the twelve month period ending __ / ___ /20 _____
(date of injury)

amounted to $ _____

Date ____ /_____ /_____ Signature _____

SECTION G: MEDICAL PRACTITIONER'S STATEMENT (please print legibly)

This form must be completed without expense to PSC Horsell Claims Solutions

IMPORTANT

1. The patient is responsible for any fee required to be paid for this statement.
2. This form can only be completed by your treating Medical Practitioner, specifically a surgeon, specialist or dentist (This section can not be completed by a Physiotherapist)
3. Blank spaces are not acceptable

Patient's Full Name: _____

How long have you known the patient? _____

1. (a) What date and where were you first consulted by the patient in connection with the present injury? _____

2. (a) What is the exact nature of the present injury?

_____

_____

(b) What is the exact location of the injury and side of body?

_____

(c) Is the current condition in any way related to their ability to work? _____

3. Is there a previous history of this or similar condition? If Yes, please give details

4. Do you consider the patient's injury to be a new injury? Yes ☐ No ☐

If 'No, please complete the following details,

(a) Recurrence of an old injury? Yes ☐ No ☐

If 'Yes', please give details: _____

_____

5. Is treatment likely to be prolonged by any complications?

_____

6. Do you consider that treatment other than that being received is essential to recovery?

_____

7. If the claimant has been hospitalised, please give name of hospital and dates

_____

8. Have you referred the patient to other services or treatment? If Yes, to whom?

_____

9. Additional remarks and prognosis. _____

I hereby certify I have personally examined the above-named patient and that 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: _____

Address: _____

Signature: _____ Qualification _____ Date: _____

INCAPACITY TO WORK STATEMENT

(To be completed if claiming for loss of income. If continuing, a new statement must be forwarded for each period absent from employment)

CERTIFICATION BY GENERAL PRACTITIONER, SURGEON, SPECIALIST or DENTIST

I examined the person named _____ on ___/___/___

In my opinion this person is/has been unfit to from ___/___/___ to ___/___/___ inclusive.

Are there any further remarks or comments you can make to assist in assessing this condition?

DOCTOR'SNAME _____

Address_____

Contactv Number: ( ) _____ Facsimile:( ) _____

DOCTOR'S SIGNATURE:_____ DATED:___/___./___

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