PERSONAL INJURY

INSURANCE

CLAIM FORM

2012/2013

Basketball VIC

PSC HORSELL
Claims Solutions

Basketball Victoria

PSC HORSELL Claims Solutions

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 to be submitted.

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 5 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

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SPORTS INJURY & PERSONAL ACCIDENT INSURANCE
FOR PERIOD 1 SEPTEMBER 2012 TO 1 SEPTEMBER 2013

WHO IS COVERED? All registered members, trialing participants, coaches, assistant coaches, voluntary workers and officials.

WHEN ARE YOU COVERED? Cover applies:

a) Engaging/Playing in official club matches including club, championship or representative matches.
b) Organised training or practice sessions for activities as described in (a) above.
c) Travelling directly between matches/activities in (a) or (b) above, and your residence or place of employment or the premises of Basketball Australia or its affiliated Associations, Leagues or Clubs.
d) Staying away from your home district during a tour for the purpose of participating in representative matches/activities.
e) Engaging in administrative or organised social activities of Basketball Australia or its affiliated associations, Leagues or Clubs.

NOTE: Some fundraising and extreme training techniques may not be covered by the definition of "Activities Covered" in this policy. Please refer to PSC Horsell Insurance brokers for confirmation that the activity is covered.

AGE LIMIT 3 to 80 years of age

MEDICAL EXPENSES

Reimbursement up to 75% of Non-Medicare medical expenses (net of recoveries from private health insurance) up to a maximum of $1,000 per injury. Claimable expenses include private hospital accommodation; ambulance transport costs; chiropractic; physiotherapy; dental services (to sound whole teeth only); ancillary medical procedures; theatre fees in private hospital where Medicare does not apply; orthotics, splints and prosthesis where an Insured Person's medical practitioner considers them medically necessary for the treatment of the injury.

An excess of $50 applies each and every claim to those not privately insured.
The policy does not provide cover for expenses incurred for which a Medicare benefit is payable; expenses incurred more than 12 months after the date of injury; accounts covered by an ambulance service whether claimed or not; accounts covered by private health insurance whether claimed or not

LOSS OF INCOME

Covers 80% of your net weekly income or up to a maximum of $200 per week, whichever is the lesser.

Cover is only provided if you were engaged full time in your occupation up to the time of your injury.

The amount of any weekly benefit payable is reduced by the amount of any periodic compensation benefits payable under any other insurance policy or employer or any other source so that the total amount of any such benefits and the weekly benefits payable do not exceed the policy limit.

Benefit Period: 52 weeks
Excess: 7 days

MEMBERSHIP BENEFIT

Pro rata amount of the annual club membership/registration fee up to a maximum of $75.00 for a season ending injury at date of injury:
Excess: Nil

STUDENT ASSISTANCE BENEFIT

Pays 80% up to $200 per week to a maximum of $2,000 any one claim for the actual cost of home tutorial by a qualified tutor which has been certified as necessary for the duration of temporary total disablement by a registered and legally qualified medical practitioner.

You must be a full time student at an accredited institution of higher learning, who does not earn an income, to be eligible for this benefit.
No compensation is payable under this section if you are seeking a benefit for Household Help.

Benefit Period: 52 weeks
Excess: 7 Days

HOUSEHOLD HELP ALLOWANCE

Pays non-income earners 80% of costs up to $200 per week to a maximum of $2,000 any one claim being for reimbursement of actual costs of domestic help certified as necessary for the duration of temporary total disablement by a registered and legally qualified medical practitioner.
No compensation is payable under this section if you are seeking a benefit for Student Assistance.

Benefit Period: 52 weeks
Excess: 7 days

FUNERAL EXPENSES

Pays 100% of the actual costs of funeral expenses of an insured person up to a maximum of $5,000

INJURY ASSISTANCE AND PARENTS INCONVENIENCE BENEFIT

Pays up to $50 per day to a maximum of $2,000 any one claim for non medical expenses incurred directly relating to the injury. For the purposes of this section, non medical expenses include transportation and accommodation costs certified as necessary by a registered and legally qualified medical practitioner. It does not include wages lost by any person.
No compensation is payable under this section if you are seeking a benefit for Loss of Income or Student Assistance or Household Help.
Benefit Period: 52 weeks with Nil Excess

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DEATH & PERMANENT DISABILITY

A lump sum benefit is payable in the event of a death or a Permanent Disability. The scale of benefits is defined in the policy.
The maximum benefit is $50,000.

HOW DO I MAKE A CLAIM?

1. Obtain claim forms from your Club or Association or from PSC Horsell Insurance Brokers – www.pscinsurancegroup.com.

2. Have the claim form fully completed as per instructions provided on the claim form.

3. Should you have any questions on how to make a claim, please contact the PSC Claims Solutions

   Jared Brennan (02) 8298 3923 or Jbrennan@pschorsell.com

ENQUIRIES

Any enquiries as to what is covered under the policy please contact your Account Manager:

Leesa Pickles on (02) 8298 3911 or lpickles@pschorsell.com

Our office details are:

PSC Horsell Insurance Brokers Pty Ltd
ABN: 30 129 444 828 AFSL: 342385
Street Address: Level 12, 189 Kent Street, Sydney NSW 2000
Postal Address: PO Box N661, Grosvenor Place NSW 1220
Phone: (02) 9247 1700 or Toll Free Outside Sydney Metro Area 1300 722 990
Fax: (02) 9247 1733

IMPORTANT NOTES

1. This insurance is underwritten by Sportscover Australia Pty Limited (Security 100% Lloyd's Syndicate 3334).
2. This information is only a summary of the cover provided. The policy with full terms and conditions and exclusions is held by The State organisation.
3. Retail Client Documents – Financial Services Guide, Statement of Advice and Insurers Product Disclosure Statement are Available from PSC Horsell Insurance Brokers or via www.pscinsurancegroup.com.

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PERSONAL INJURY CLAIM FORM

(Every question <u>MUST</u> 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

DIRECT DEBIT DETAILS: 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: ____

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)

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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: ……../……../……..

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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:______________

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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	$

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SECTION E: 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 o No o (if Yes, give details) ______________
3. Have you engaged in any other income earning employment since you became disabled? Yes o No o (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 o No o

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 F: 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 o No o

If 'No, please complete the following details,

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

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: ________

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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____

Contact Number: ( ) ________________________ Facsimile:( ) _______________________

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