JLT Sport Personal Injury Claim Form

Australian Football National Risk Protection Programme

Important Information

Who should use this claim form?

You should complete this form if:

- ☑ **Insured -** You are a player, umpire, official or volunteer (Insured Person) of a League/Club (the Insured) covered within the Australian Football National Risk Protection Programme; and
- ☑ **Injured -** You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned football-related event/activity; and
- ☑ **Non-Medicare -** You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on JLT Sport's web site www.jltsport.com.au/afl .

What is covered?

The Australian Football National Risk Protection Programme's Personal Injury cover provides reimbursement for Non-Medicare Medical costs and/or Loss of Income cover for 12 months from the date of injury.

Loss of Income Cover is not automatically provided. If you are considering a Loss of Income claim, please check that your club has purchased Loss of Income cover before completing Section C. Please note - claimants must exhaust all of their sick leave benefits before being able to claim loss of income through this policy.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Medicare Gap. Non-Medicare Medical Benefits are covered up to the limits outlined below.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS).

Bronze, Silver, Gold or Platinum?

The following table outlines the reimbursement capacity for the various cover levels within the Australian Football National Risk Protection Programme.

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursed	75% Reimbursed	90% Reimbursed	90% Reimbursed
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim

All clubs receive, at least, the minimum Non-Medicare Medical Benefits cover (Bronze) at the commencement of each period of cover. Clubs/Leagues may choose to upgrade to a higher level of cover for an additional premium. Upgraded cover is valid only from the date of purchase.

If you do not know what level your club has purchased for this period of cover, please contact your club and/or league for details.

What is NOT covered?

The following examples demonstrate some areas not covered by the Personal Accident cover:

- ☒ Medicare items (see below);
- ☒ the Medicare Gap (see below);
- ☒ Injuries sustained whilst playing against medical advice.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS) for further details.

What does "Non-Medicare" mean?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the "Medicare Gap".

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer or the JLT Trustee to reimburse any part of a Medicare Item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Australian Football National Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or www.medicare.gov.au

Please note: some Private Health Funds may offer Medicare Gap Insurance Cover. JLT Sport is not a Private Health Fund, nor do we offer Private Health Insurance.

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

WHAT'S COVERED?

NON-MEDICARE EXAMPLES:

Ambulance

Physiotherapist

Dental

Private Hospital Accom.

Chiropractor

WHAT'S NOT COVERED?

MEDICARE EXAMPLES:

Doctor

Surgeon

Surgeon's Assistant

Anaesthetist

X-Rays

Public Hospitals

Send completed forms to:

ECHELON CLAIMS SERVICES

sportsclaims@echelonaustralia.com.au

Or

GPO Box 1693

Adelaide SA 5001

Or

Fax: (08) 8235 6107

Claims Enquiries:

Phone: 1800 640 009

www.jltsport.com.au

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Claim Conditions

How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
   - o Your claim form may be returned if there is important information missing
   - o For assistance, please contact Echelon on 1800 640 009
2. Send your completed claim form to Echelon within **270 days** from the date of injury
   - o ***Do not*** wait until your treatments have concluded before you lodge your claim
   - o You can lodge your claim even if you have no out of pocket expenses
3. Echelon will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information
4. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to Echelon as your treatment continues (for up to 12 months from the date of injury).

What should I send with my claim?

Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to Echelon.

Retain a copy - Please submit only original receipts to Echelon. We recommend you retain a copy of all receipts and your Claim Form for your records.

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send Echelon a copy of your Private Health rebate advice.

Claims Conditions:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to Echelon within 270 days from the date of injury.

Subject to the Trustee's discretion and/or the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by Echelon must be provided by you upon request and at your expense (if applicable).

Who is Echelon?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of JLT. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the Australian Football National Risk Protection Programme.

Who is JLT Sport?

JLT Sport is the appointed broker for the Australian Football National Risk Protection Programme. As a division of Jardine Lloyd Thompson Pty Ltd, JLT Sport is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries

Collection Statement under Privacy Act 1988

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Echelon Australia Pty Ltd (and our related entities) (Echelon) draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling, loss adjusting or risk management (depending on your requirements). Other purposes include providing you with information about other Echelon products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Echelon related companies.
- Your personal information may be sent to our administrative processing centre in Mumbai (India) and to other JLT Group companies and to insurers and reinsurers in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent. We will use and disclose your personal information in accordance with our Privacy Policy.
- Our Privacy Policy can be accessed on our website (www.echelonaustralia.com.au). For further information contact your account executive or the Echelon Privacy Officer:

Echelon Australia Pty Ltd
Level 11, 66 Clarence Street, Sydney NSW 2000
Phone: +61 2 9290 8000

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

Complete ALL sections

Send within 270 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

Send completed forms to:

ECHELON CLAIMS SERVICES

sportsclaims@echelonaustralia.com.au

Or

GPO Box 1693

Adelaide SA 5001

Or

Fax: (08) 8235 6107

Claims Enquiries:

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Section A: Claimant's Details

PERSONAL INFORMATION:

Claimant's Name: First Name _____ Surname _____

Postal Address: Street Address _____ State _____ Postcode _____

Occupation: _____

Contact Details: Email Address _____ Phone Number (Bus. Hours) _____

Personal Details: Date of Birth / / ○ Male ○ Female Gender — Date of Injury / / — Time of Injury AM / PM

Club Name: _____

League Name:

Describe your injury and how it happened (please attached additional pages if required):

INJURY RESEARCH DATA:

Session: ○ Playing ○ Training ○ Travelling ○ Event ○ Other ○ Warm up/down

Injured Person ○ Player ○ Umpire ○ Official ○ Trainer ○ Other _____

Grade: ○ Senior ○ Junior ○ Not Applicable

Surface Conditions: ○ Wet ○ Dry ○ Muddy ○ Indoor ○ Other

Period: ○ 1st ○ 2nd ○ 3rd ○ 4th ○ Other

Resumption date(s): / / When will you resume WORK? — / / When will you resume TRAINING? — / / When will you resume PLAYING?

Private Health Cover: ○ Yes ○ No — Do you have Private Health Insurance? — If YES, what is the name of your Private Health Insurance Provider? _____

Private Health Coverage: ○ Dental ○ Physiotherapy ○ Ambulance ○ Hospital

Ambulance Membership: ○ Yes ○ No

PAYMENT DETAILS:

EFT Payee Details: Bank _____ Name on Account _____ BSB _____ Account Number _____

CLAIMANT DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. The injury was sustained accidentally during a football activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/afl.

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).

D. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, the Trustee and the Claims Managers.

E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish JLT's representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.

F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

G. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.

H. You authorise any and all information regarding claims with any other insurer to be released to JLT's representatives.

Claimant's Signature* _____ Date: / /

Parent or Guardian if under 18 years

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

Send completed forms to:

ECHELON CLAIMS SERVICES

sportsclaims@echelonaustralia.com.au

Or

GPO Box 1693

Adelaide SA 5001

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Fax: (08) 8235 6107

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Section B: Club Declaration – to be signed by the Club President

CLUB DETAILS:

Claimant's Name: First Name _____ Surname _____

Club Name: _____

Club Contact: Club Contact Person _____ Position within Club _____

Contact Details: Contact Phone Number _____ Email Address _____

League Name: _____

Registration Details: ○ Yes ○ No
Is the Club Registered for this Period of Cover? *(This claim will not be able to be accepted until online registration has occurred)*

Non-Medicare Cover: ○ Bronze (50%) ○ Silver (75%) ○ Gold (90%) ○ Platinum (90%)
If known > What Cover Level has the Club purchased for this Period of Cover? *(Optional – if unsure, please leave blank)*

Loss of Income Cover: ○ Yes ○ No $ _____ Per week
If known > Has the Club purchased Loss of Income this year? If YES, what is weekly limit purchased by the Club (if known)?

INJURY DETAILS:

Date/Time: / / Date of Injury _____ AM PM Time of Injury

Circumstances: ○ Playing ○ Training ○ Travelling ○ Other

Opposition Club Name: _____
If applicable

Ground/Location: _____
Where did the injury occur?

Resumption date(s): ○ Yes ○ No Has the Claimant returned to TRAINING? / / If YES, date Claimant returned?

○ Yes ○ No Has the Claimant returned to COMPETITION? / / If YES, date Claimant returned?

CLUB DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are the Clubs President
B. You are independent to the claimant (i.e. not a family member) / if not ensure Club Vice President signs this declaration
C. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
D. You declare the Claimant's injury was sustained accidentally during the football activity noted above and is not a pre-existing illness or condition.
E. You understand that registering your club with JLT Sport is a requirement of the Australian Football National Risk Protection Programme for each Period of Cover.
F. You confirm the club's level of cover as per the details provided above.

Club President's Signature: _____ Date: / /

Important Information for Clubs/Leagues:

The following table outlines the reimbursement capacity for all levels within the Australian Football National Risk Protection Programme.

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursed	75% Reimbursed	90% Reimbursed	90% Reimbursed
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim

All clubs receive, at least, the minimum cover (Bronze) at the commencement of each Period of Cover. Clubs/Leagues may upgrade to a higher level of cover for an additional premium. Upgraded cover is valid only from the date of purchase. It is the responsibility of clubs to be aware and maintain details of their cover level.

Loss of Income is not an automatic cover within the Australian Football National Risk Protection Programme. Clubs may purchase this additional cover for an additional premium. If your club has not purchased Loss of Income Cover, claimants from your club will not be eligible to lodge a loss of income claim through JLT Sport.

For Upgrade and Coverage details, please refer to JLT Sport's web site at www.jltsport.com.au/afl

Important Information
Claim Conditions
Section A: Claimant's Details
Section B: Club Declaration
Section C: Loss of Income
Section D: Physician's Report

All clubs must register with JLT Sport each year

Clubs failing to register may incur delays for claimants

To register your club please visit **www.jltsport.com.au/afl**

Send completed forms to:
ECHELON CLAIMS SERVICES
sportsclaims@echelonaustralia.com.au
Or
GPO Box 1693
Adelaide SA 5001
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Section C: Loss of Income

TO BE COMPLETED BY THE CLAIMANT:

Do you wish to claim Loss of Income Benefits? ○ Yes ○ No If NO, proceed to SECTION D

If you are NOT claiming Loss of Income Benefits please do not complete this section. Please proceed to Section D.

If you wish to claim Loss of Income Benefits, ensure your club has purchased Loss of Income Cover for this Period of Cover.

Please obtain details of your club's Loss of Income Cover before completing the following questions.

IMPORTANT INFORMATION – The excess applicable is 14 or 49 days (as purchased by the club), unless your sick leave balance exceeds this, in which case your sick leave balance becomes your excess period

Has your club purchased Loss of Income this year? ○ Yes ○ No $ _____ Per week

If YES, what is weekly limit purchased by the Club?

Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)? ○ Yes ○ No

Have you ever made previous claims in respect to a personal accident insurance policy or plan? ○ Yes ○ No

Have you engaged in any other income earning employment since you became injured? ○ Yes ○ No

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):

Claimant's Name: _____ (First Name) _____ (Surname)

Employer/Business: _____ (Employer/Company Name) _____ (Contact Person)

Postal Address: _____ (Street Address) _____ (State) _____ (Postcode)

Contact Details: _____ (Email Address) _____ (Phone (Bus. Hours)) _____ (Mobile)

Employment Status: ○ Full Time ○ Part Time ○ Casual ○ Self Employed

Employment Details: $ _____ (Employee's NET weekly salary) $ _____ (Employee's GROSS week salary) / / (Date Employee commenced with company.)

If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.

Injury Details: / / (Date employee ceased work) / / (Date expected to resume duties)

Returned to Work: ○ Yes ○ No / / (Has the Employee returned to work? If YES, what date did the Employee return?)

Salary Received: ○ Yes ○ No If YES, what for?

During the period of incapacity, has the employee received a salary?

Sick Leave: ○ Yes ○ No from / / to / /

Annual Leave: ○ Yes ○ No from / / to / /

Other: ○ Yes ○ No from / / to / /

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived from playing sport.

EMPLOYER'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are the Claimant's current employer (or accountant if the claimant is self-employed),

B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,

C. You will supply upon request any further information as required for the determination of this claim.

Employer's Signature: _____ Date: / /

** Accountant's signature (if claimant is self-employed)*

Important Information

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Section A: Claimant's Details

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Please check your that your club has purchased Loss of Income Cover

Send completed forms to:

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Or

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Fax: (08) 8235 6107

Claims Enquiries:

Phone: 1800 640 009

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Section D: Physician's Report

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

PHYSICIAN'S REPORT

Claimant's Name: _____ (First Name) _____ (Surname)

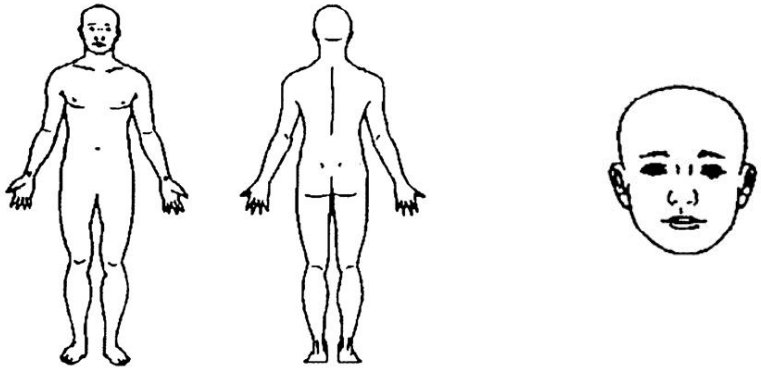
Physician's Details: _____ (Physician's Name) _____ (Phone Number)

Injury Consultation: ___/___/___ (Date of Injury) ___/___/___ (Date of Consultation)

Diagnosis/History of injury:

Injury Location:
- ○ Ankle ○ Arm ○ Dental ○ Facial ○ Foot
- ○ Hand ○ Head ○ Internal ○ Knee ○ Lower Leg
- ○ Shoulder ○ Spinal ○ Torso ○ Upper Leg ○ Pubis

Please mark (×) the anatomical location below:



Injury Type:
- ○ Amputation ○ Bruising ○ Concussion ○ Cut ○ Death
- ○ Dental ○ Dislocation ○ Fracture/Break ○ Rupture ○ Sprain
- ○ Strain ○ Accumulative ○ Osteitis Pubis ○ Fatigue/Debilitation

First Medical Treatment: ___/___/___ (Date of treatment) _____ (Name of attending physician)

Do you consider the Claimant's injury to be a NEW injury? ○ Yes ○ No

Do you consider the Claimant's injury to be the result of:
A: Sudden and unforseen incident or
B: The result of accumulative wear and tear? ○ A ○ B

Does the Claimant have any congenital defects or chronic deases? ○ Yes ○ No

If YES, please provide details and a description (dates, name of treating doctor, etc):

Please continue to Page 7.

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Section D: Physician's Report

PHYSICIAN'S REPORT (continued)

Have you referred the patient to any other services or treatment? ○ Yes ○ No

If YES, please provide details below:

Physiotherapy: ○ Yes ○ No _____ If YES, approx. number of treatments required.

Chiropractics: ○ Yes ○ No _____ If YES, approx. number of treatments required.

Surgery: ○ Yes ○ No _____ If YES, please provide details

Other: ○ Yes ○ No _____ If YES, please provide details

Has the Claimant been able to do any work since the injury occurred? ○ Yes ○ No

What date do you advise the Claimant to return to playing Football? ___/___/___

If YES, please provide details

PHYSICIAN'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form;

B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Signature: _____ Date: ___/___/___

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT:

I, _____ (Medical Practitioner's Name) examined _____ (Claimant's Name) on ___/___/___ (Date of examination)

In my opinion, this person is/has been unfit to work from ___/___/___ (First day of incapacity) to ___/___/___ (Last day of incapacity) inclusive.

Please provide any further comments in regard to your assessment of the injury/condition?

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form;

B. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature: _____ Date: ___/___/___

For more information, please refer to JLT Sport's web site:

www.jltsport.com.au/afl

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