

Office use only	
Policy Number:	
Claim Number:	

BASKETBALL VICTORIA



PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;



Fullerton Health Corporate Services

Level 10, 33 York Street Sydney NSW 2000 Phone (02) 8256 1770 Fax (02) 8256 1775 Email claims@fullertonhealthcs.com.au



INSURANCE BROKER FOR BASKETBALL VIC;

Authorised Representative No. 432898 a corporate authorised representative of Willis Australia Limited AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547

BASKETBALL VIC 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 for members aged 18-75 or \$20,000 for persons under 18 years old or over 75 years old.

Non Medicare Medical Expenses

Reimburses up to 75% of Non-Medicare medical expenses up to a maximum of \$1,000 (\$5,000 for Volunteers) with Ambulance Transport Costs reimbursed 100% up to the maximum benefit limit. Claimable expenses are private hospital bed and theatre fee, 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 12 months from the date of injury.

Student Tutorial Costs

Reimburses up to 80% of costs incurred up to a maximum of \$200 per week for home tuition by a qualified tutor if the Injury stops the Insured Person from going to their external tutor outside the home for up to 52 weeks with a 7 day excess period

Domestic Help Benefit

Reimburses up to 80% of costs incurred up to a maximum of \$200 per week for a recognized and licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependant children such as child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 7 day excess period

Loss of Income

Weekly Benefit 100% of earnings, if prevented from working in your occupation up to a maximum of \$250 per week (\$700 per week for Volunteers). The benefit period is 52 weeks and the excess is 7 days.

Funeral Benefit

We will pay up to an additional \$10,000 for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

Important Notes

This insurance cover is underwritten by:-

Arch Underwriting at Lloyd's (Australia) Pty Ltd Level 4, 68 York Street, Sydney NSW 2000 ABN 51 051 374 228

- 1. This summary of cover provides factual information about the Basketball VIC Insurance Program.
- 2. This information is only a summary of the cover provided. The policy with full conditions is available at www.vinsurancegroup.com/basketball or by contacting Basketball VIC.
- 3. This insurance program commences on 1 September 2018 to 1 September 2019.
- 4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Basketball VIC 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.
- 5. Basketball VIC 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 Basketball VIC insurance program can be obtained by visiting

http://www.vinsurancegroup.com/basketball



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HOW TO MAKE A CLAIM

Dear Basketball VIC 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 and sign and date the Declaration.
- 3. For claims involving Loss of Income:
 - a) You must complete page 7 and have your employer/salary officer complete page 7. If self-employed, you must have your accountant complete these details;
 - b) You must attach at least two payslips including the most recent full period pre-Injury.
 - c) You must complete the Tax File Number Declaration form on page 8. If you are employed and pay tax on the income you earn (known as PAYE), the ATO requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be fowarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.
 - d) Have your Attending Physician complete the page titled "Doctor's Statement" on page 11. This may be completed by a Physiotherapist for minor injuries only.
- 4. For claims involving Non-Medicare medical expenses:
 - a) Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist).
 - b) Have your Attending Physician complete the "Attending Physician" statement on pages 10 & 11.
- 5. Please attach all itemised receipts (be sure to copy them before you claim with your health fund as they will retain the original). Hospital claims must be accompanied by an itemised Invoice, not just the estimate. 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 Australian Health Insurance Act does not permit the insurer 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 bed and theatre fees, 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.

- **6.** Once you have fully completed all sections of the claim form, please have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.
- Once you have completed your claim form, please forward to Fullerton Health Corporate Services. They handle all claims for the insurer.

Fullerton Health Corporate Services

Level 10, 33 York Street Sydney NSW 2000

Phone +61 2 8256 1770 Fax +61 2 8256 1775

Email claims@fullertonhealthcs.com.au

- 8. Reimbursement will be paid to you directly by Fullerton Health Corporate Services by deposit into your nominated bank account.
- 9. Once your claim is registered, you can submit ongoing receipts via Fullerton Health. Fullerton Health can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.
- **10.** If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the V-Insurance Group Team on ph: (02) 8599 8660 or 1300 945 547.



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PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS				
Association Name(compulsory):	Member No (if applicable):	Club Name	e:	
Claimant's Name:				
Name of team/age group/grade:				
Gender (please tick): Male Female	Occupation:		Date of Birth:	/ /
Address			State F	Postcode
Email:				
Phone Number (Work):	Home: ()			
Mobile Number:				
Please tick the category applicable If Other, please advise		☐ Coach	☐ Umpire	☐ Other
DECLARATION AGREEMEN	IT AND AUTHORISATION	I BY CLAIN	MANT	
I	e concealed information of a mate	and complete	e in every detail. I a	agree that if I made any
I hereby authorise Arch Underwriting information about me from and to the practice, any medical services provinstitutions including banks, the Taxa consultation, treatment including prespractice records, vocational and emportant entermination of the practice records are the practice records.	Health Insurance Commission, a der, any past or present employ ation Department or my accounta acciption of medication, copies of ployment records from past and	any insurance yer, investigat ant with respe hospital medi	company, any hospors, insurance refect to any sickness, cal records and tes	pital, physician, medical rence bureau, financial injury, medical history, its and reports, medical
I consent to the collection, use and dis assess the claim. Arch Underwriting c policy which is readily available upon i	omplies with the obligations of the			
Signature of Claimant (or Legal Guardian if under 18 years of age	e)	Dat	e	
Name of Guardian:			-	



DECLARATION BY ASSOCIATION	
Name of Association/Club:	Name of Association/Club Official making this statement:
Official Position:	Telephone Number: ()
	Email:
Address	State Postcode
	was a registered and Financial member of this Basketball VIC Club and was an insured g Limited at the time of the accident, that the information contained in this statement is ferred to in this claim form is true and correct.
Do you have any comments in relation to this claim? If yes, please detail below	☐ Yes ☐ No
Dated: / / Signature of Associat	ion/Club Official:
ACCIDENT DETAILS	
Describe how the accident happened?	
Describe your injury?	
When did your accident occur?	
Date: / /	Time: am/pm
l	Officially organised competition Officially organised training
	Social or private competition
	Travelling to and from activity
	Sanctioned fundraising/social event
Please provide the address of where the injury occurre	d?
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 t	he 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?



Advise when you did (or expect to):	Cease work/normal activition Cease training Cease participating Resume work/normal activition Resume training Resume participating	vities
Have you ever had this injury (similar injuries) i	n the past? ☐ Yes ☐ No	If yes, please advise when?
The following information is required for Bas answering these questions will not affect you		sist with Risk Management,
Where did your injury occur? (please tick)	Indoor Outdoor	_ _
What type of team were you playing in?	Women's Men's Mixed Youth	
Surface at point of injury? (please tick)	Timber Synthetic Concrete / Asphal Other, please adv	
Weather conditions? (please tick)	Fine Rain Showers Extreme Heat Extreme Cold	
Surface Conditions? (please tick)	Wet Dry Other, please adv	ise 🗆
Quarter/half injured? (please tick)	1 st Quarter 2 nd Quarter	



3rd Quarter

4th Quarter Not applicable

LOSS OF INCOME (ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF (please tick the box)	INCOME) Yes No
Can compensation be claimed under worker's compens Income?	ation or any other insurance including Loss of
2. Have you ever made any previous claims in respect to perinsurance?	ersonal accident insurance or any other similar
3. Have you engaged in any other income earning employ	ment since you have been injured?
THE FOLLOWING SECTION MUST BE COMPLETED B IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNT	
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: Average Gross Base Salary \$	Date commenced employment with company: / /
Income Definition: ☐ Self Employed ☐ Full Time	☐ Part Time ☐ Casual
During the period of incapacity the employee has receive	ed
Has the employee returned to work? ☐ Yes	/
Has the employee lodged or intending to lodge a Worker A. IF EMPLOYED	s Compensation Claim?
Salary officer's name:	Phone Number: ()
	Email:
Salary officer's signature:	Date: / /
Company Stamp:	ABN/ACN:
B. IF SELF EMPLOYED	
Accountant's name:	Phone Number: ()
Accountant's signature:	Date: / /
Accountant's Company Stamp:	



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Tax file number declaration

This declaration is NOT an application for a tax file number.

п	l Ise a	hlack	or blue	nen an	d nrint	clearly in	RI	OCK I	_ETTERS.

YOU ONLY NEED TO
COMPLETE THIS PAGE
IF YOU ARE CLAIMING LOSS
OF INCOME (refer page 3, 3c

ato.gov.au ■ Print X in the appropriat ■ Read all the instructions	e boxes. including the privacy statement before you complete this declaration.
Section A: To be completed by the PAYEE	6 On what basis are you paid? (Select only one.)
1 What is your tax file number (TFN)?	Full-time Part-time Labour Superannuation or annuity employment hire income stream
OR I have made a separate application/enquiry to the ATO for a new or existing TFN. OR I have made a separate application/enquiry to the ATO for a new or existing TFN. OR I am claiming an exemption because I am under	7 Are you an Australian resident for tax purposes? (Visit ato.gov.au/residency to check)
of the instructions. 18 years of age and do not earn enough to pay tax.	8 Do you want to claim the tax-free threshold from this payer?
OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance.	Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.
2 What is your name? Title: Mr Mrs Miss Ms Surname or family name	Answer no here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.
First given name	9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?
Other given names	Yes Complete a Withholding declaration (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions.
	10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?
3 If you have changed your name since you last dealt with the ATO, provide your previous family name.	Yes Complete a Withholding declaration (NAT 3093).
	11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?
4 What is your date of birth? Day Month Year Year	Yes Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment.
5 What is your home address in Australia?	(b) Do you have a Financial Supplement de \[\text{\tinx{\text{\tinx{\text{\tinx{\text{\tex{\tex
	Yes repayment that may be raised on your notice of assessment.
	DECLARATION by payee: I declare that the information I have given is true and correct. Signature Date
Suburb/town/locality State/territory State/territory Suburb/town/locality Postcode	You MUST SIGN here Day Month Year Year
	There are penalties for deliberately making a false or misleading statement.
Once section A is completed and signed, give it to your payer to com	plete section B.
Section B: To be completed by the PAYER (if you are r	not lodging online)
1 What is your Australian business number (ABN) or withholding payer number? Branch number (if applicable)	4 What is your business address?
3 0 0 7 4 8 6 4 6 0 9 0 0 4	LEVEL 10
2 If you don't have an ABN or withholding payer number, have you applied for one?	3 3 Y O R K S T R E E T
Yes No	SYDNEY
What is your legal name or registered business name (or your individual name if not in business)?	State/territory Postcode 2 0 0 0
FULLERTON HEALTH	5 Who is your contact person?
CORPORATE SERVICES	ANTHONY ROUHANA
	Business phone number 0 2 8 2 5 6 1 7 7 0
DECLARATION by payer: I declare that the information I have given is true and correct.	6 If you no longer make payments to this payee, print X in this box.
Signature of payer Date Day Month Year Vear	Return the completed original ATO copy to: Australian Taxation Office PO Box 9004 PENRITH NSW 2740 IMPORTANT See next page for: payer obligations lodging online.
There are penalties for deliberately making a false or misleading statement.	

NON MEDICARE ME (ONLY COMPLETE THIS SECTION					
Do not attach accounts properties contribute to any charge Are you a member of an Are you a member of a F	s covered by Medicare Ambulance Service?	e (including the Medi)	permit us to
If yes, please provide de Hospital Cover? Extra's covering, Physio			Yes □ No)	
Itemised accounts and re Insurance.	eceipts must be submi	tted together with de	etails of Benefit	s from any Private	Health
NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
			<u> </u>		
				Total Less Excess	
			TOTAL AMO	DUNT OF CLAIM	
If claiming physiotherapy	y or other specialist tre	atment, please prov	ide the name a	nd address of refe	rring doctor:
Name of Doctor:					
Address:					



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AR No. 432898 Willis Australia Limited AFSL: 240600 Phone (02) 8599 8660 or local call cost only 1300 945 547 Completed claim forms should be sent to Fullerton Health Corporate Services, Level 10, 33 York Street, Sydney NSW 2000 or via email claims@fullertonheathcs.com.au

Office use only	
Policy Number:	
Claim Number:	

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

IMPORTANT

- 1. The patient is responsible for any fee for this statement.
- 2. This form can <u>only</u> be completed by the treating Medical Practitioner, Surgeon (Physiotherapist may complete for minor injuries only).
- 3. If "Yes" answered to any of the following, please give details.
- 4. Dashes or blank spaces are not acceptable.

TO BE COMPLETED BY THE ATTENDING PHYSI	CIAN
Patient's Full Name:	How long have you known the patient?
What date were you first consulted by the patient in connect	tion with the present injury? / /
Patient's Occupation:	
Are you the patient's regular general practitioner?	∕es □ No
What is the exact nature of the present injury? (Please deta	il symptoms and diagnosis)
Front	Back Head



A recurrence of an old injury?	☐ Yes ☐ No
If yes, please state condition and advise when previous treatment w	vas given
Have you referred the patient to any other services or treatment?	☐ Yes ☐ No
Please specify the type and approximate number of treatments requ	uired:
☐ Physiotherapy	
□ Other	
Have any surgical procedures been performed? If yes, please spec	cify
What surgical procedures are contemplated?	
Are there any further remarks which may assist in assessing this co	ondition?
	_
Is there any permanent disability at present?	☐ Yes ☐ No
If yes, please explain giving estimated percentage loss of function	
Was the patient obliged to cease work?	☐ Yes ☐ No
	If Yes, from/
	Some duties
If so, when do you expect the patient to resume:	
	Full duties
What date do you advise the patient may return to basketball?	Full duties
Does the patient have any congenital defects or chronic diseases?	☐ Yes ☐ No
	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are	☐ Yes ☐ No
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital ar Name of Hospital: Date Admitted / /	☐ Yes ☐ No Ind dates hospitalised: Date Released
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital ar Name of Hospital: Date Admitted	☐ Yes ☐ No Ind dates hospitalised: Date Released
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital ar Name of Hospital: Date Admitted / /	☐ Yes ☐ No Ind dates hospitalised: Date Released / /
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are Name of Hospital: Date Admitted /// CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opinithis claim form are consistent with the patient's injury.	☐ Yes ☐ No Ind dates hospitalised: Date Released / /
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are Name of Hospital: Date Admitted / / CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opinithis claim form are consistent with the patient's injury. Name: Telephone	☐ Yes ☐ No Ind dates hospitalised: Date Released / /
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are Name of Hospital: Date Admitted / / CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opinithis claim form are consistent with the patient's injury. Name: Telephone	Yes No Indicates hospitalised: Date Released / / ion the statements made in the Accident details section of Number: ()
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are Name of Hospital: Date Admitted /// CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opin this claim form are consistent with the patient's injury. Name: Telephone Fax: ()	The statements made in the Accident details section of Number: ()
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital at Name of Hospital: Date Admitted / / CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opin this claim form are consistent with the patient's injury. Name: Telephone Fax: () Email: Address: Signature: Qualification	The statements made in the Accident details section of Number: ()
Does the patient have any congenital defects or chronic diseases? If yes, please give dates, name of treating doctor and describe If the patient has been hospitalised, please give name of hospital are Name of Hospital: Date Admitted /// CERTIFICATION BY ATTENDING PHYSICIAN I hereby certify I have personally examined the above named patient and in my opin this claim form are consistent with the patient's injury. Name: Telephone Fax: ()	The statements made in the Accident details section of Number: ()



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METHOD OF PAYMENT
Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account
Please complete the details below.
NAME OF CLAIMANT
Γitle: □ Mr □ Mrs □ Ms □ Miss
Name:
BANK ACCOUNT DETAILS
SSB number (all 6 digits are required here) Account Number
Account Holder's Full name:
Bank, Credit Union, Building Society name:
Branch:
DECLARATION
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited 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:
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment. Fullerton Health Corporate Services is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied
 hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment. Fullerton Health Corporate Services is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details. I agree to Fullerton Health Corporate Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Fullerton Health Corporate Services disclosure of this information, to Fullerton Health Corporate Services 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 <i>Privacy Act 1988</i>. 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
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment. • Fullerton Health Corporate Services is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details. • I agree to Fullerton Health Corporate Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Fullerton Health Corporate Services disclosure of this information, to Fullerton Health Corporate Services 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 <i>Privacy Act 1988</i> . 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
hereby authorise Fullerton Health Corporate Services as agents of Arch Underwriting Limited to make any bayments 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment. Fullerton Health Corporate Services is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details. I agree to Fullerton Health Corporate Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Fullerton Health Corporate Services disclosure of this information, to Fullerton Health Corporate Services 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 <i>Privacy Act 1988</i> . 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.

