NSW Junior Rugby League – Sports Injury Claim Form

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Gow-Gates Insurance Brokers and Financial Services

QBE

NSW JUNIOR RUGBY LEAGUE

This information must be completed and signed by the **Injured Person**, **a Club Official and your District Administrator** and forwarded to **Cunningham Lindsey** within 30 days of injury. **DO NOT** wait for all accounts / receipts.

We may be unable to deal with your claim properly if you have not answered all questions fully.

IMPORTANT INFORMATION: PLEASE READ

IMPORTANT NOTE REGARDING CLAIMS FOR MEDICAL EXPENSES

We do not provide cover for any account that is fully or partially covered by Medicare. This means we do not cover expenses claimable from Medicare or the Medicare Gap.

The reason for this is we're not permitted by law to do so. Please do not send us any account/receipt that is covered by Medicare or Medicare statements. Do not wait for any account / receipt before sending.

We **do cover** Non Medicare medical expenses. We will pay the percentage amount shown in the policy schedule of charges for Private Hospital, Dental, Ambulance, Chiropractic treatment, Physiotherapy, or any similar provider of medical services provided always that such treatment is certified necessary by a legally qualified medical practitioner.

HOW TO CLAIM MEDICAL EXPENSES ONLY

When claiming for Non Medicare expenses you must have the **'Sports Injury Report Form'** fully completed.

Medical treatment must be certified necessary by a legally qualified medical practitioner. This could be your treating doctor or dentist. The **Attending Physicians Statement** must be fully completed (without expense to the insurer) prior to submitting a claim.

Please note that medical cover is **limited for 12 months** from the date of accident.

For each and every claim a $100.00 excess will apply ($50 if you are in a private Health Fund and $25 for ambulance only claims).

Please check with your club for exact cover.

HOW TO CLAIM LOSS OF INCOME

When claiming for Loss of Income you must have the **'Sports Injury Report Form'** fully completed including the section to be completed by your Employer. If self employed you will need to attach proof of earnings such as a tax return.

The policy has a 14 day elimination period (excess) this means the first 2 weeks off work will not be reimbursed.

You must have your treating doctor complete the **Attending Physicians Statement** (without expense to the insurer) prior to submitting a claim.

If your disability is continuing, please forward medical certificates every two weeks. Loss of income benefits will not be paid until all statements and documents are submitted.

PLEASE REMEMBER

1. If you have Private Health Insurance, you must submit details to your insurer prior to claiming from us.
2. Attach evidence of receipts / accounts for the treatment you are claiming.
3. Excesses and percentages of cover apply under the policy.

It is suggested that you check these details with your Club/Association representative prior to submitting a claim to us.

JUNIOR LEAGUE ASSOCIATION NSW

Please return this form to – Cunningham Lindsey Australia Pty Ltd, PO Box 1438, Parramatta NSW 2124 Telephone: 1300 723 690
Email: sports@cl-au.com – Facsimile: 02 9633 5521

Player's Name*:					
Postal Address*:				Post Code*:	
Telephone:	Home		Work		Mobile
Date of Birth*:		Gender M ☐ F ☐		Email	
Normal occupation prior to disablement*:					
Name of Club, Grade & Team*:		Registration Number*:		Position Played:	

Details of injury

A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).

Type of Injury*:		How did injury occur?	
Place where you were injured:			
Date of Injury*:	Time:	Training: Yes ☐ No ☐	Playing: Yes ☐ No ☐

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition(s):		Date:		Treated By:	

To be completed by the Club Secretary/Treasurer*. Please ensure that all questions have been fully answered.

Name of player injured			
Grade with the Club			
Name of Club			
Secretary/Treasurer's Name		Telephone	
Address		Post Code	

I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.

Signature		Date		Witness		Date	

District Administrator's Acknowledgment:	(Signature and Date)		District:

Details of Non Medicare expenses claimed. NB Only forward accounts for services which are not subject to a Medicare rebate ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

Are you a member of a private health fund*? Yes ☐ No ☐

If yes, which one?

Hospital Cover Yes ☐ No ☐ Extras covering dental, physio, etc. Yes ☐ No ☐

	Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)						
b)						
c)						
d)						

Add an extra page if insufficient space.

When did you first consult a physician for this condition?*

When did you become totally disabled (unable to work)?*

When were you able to again perform part of your occupational duties?*

If still totally disabled, when do you expect your disability to terminate?*

When will you resume training?*

Give name and address and period of stay at hospital (if applicable):

Hospital	Address	From	To

a. Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

b. Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)

Name	Address	Telephone

Loss of income claims

1. **If self employed** (Please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant?

Name	Address	Telephone

2. **If employed as a wage earner** (To be completed by your employer)

I HEREBY CERTIFY THAT: has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on

They have been incapacitated since and is expected to/did resume duties on

Their gross basic salary (excluding bonuses, commission and overtime)at the date of injury was – ($) per week

During this period of incapacity he/she received:

a) Normal pay $ From to

b) Sick pay $ From to

c) Workers Compensation $ From to

Other (please specify) $ From to

They have been employed since Their sick leave entitlements at date of injury is days

Name of Company

Address

Name of Manager or Paymaster Signature

Telephone Date Company stamp

Are they claiming or entitled to claim any other form of income (eg. Dept of Social Services, loss of income protection insurance, etc.)?
If so, please provide details.

Payment details

Payment methods (Please note we are not liable for any bank processing fees on the receiver side)

1. Australian bank account ☐ Provide details below ☐ Deposit slip provided

Bank name		Account name	
BSB		Account number	

2. Australian dollar cheques mailed to address above (please provide alternate address below if required) ☐

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at www.qbe.com.au/privacy, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Payment declaration and authorisation

I hereby authorise Cunningham Lindsey Australia Pty Ltd as agents for QBE payment by EFT into my bank account as specified above. I understand and agree that the following conditions will apply:

1. I agree that the payment is made when Cunningham Lindsey Australia Pty Ltd has instructed its bank to credit the nominated account and that I release Cunningham Lindsey Australia Pty Ltd from any further liability in relation to this payment.
2. Cunningham Lindsey Australia Pty Ltd 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.
3. I agree to Cunningham Lindsey Australia Pty Ltd collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Cunningham Lindsey Australia Pty Ltd disclosure of this information, to Cunningham Lindsey Australia Pty Ltd 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 the wrong account.

Signature of player (or parent/guardian if under 18 years of age)		Date	
Please print name*:			

Attending Physicians Statement* (The insured is responsible for completion of this form without expense to the company)

Patient's Name		Gender	M ☐ F ☐
Address			

What is disabling the patient? (Please give a complete diagnosis of this condition)

HISTORY:

1. When did the patient first receive medical treatment?

2. Was there a previous history of this or a similar condition? Yes ☐ No ☐

If yes, please state condition and advise when previous treatment given.

3. a) How long have you known the patient?

b) Are you the regular general practitioner? If no please advise who is? Yes ☐ No ☐

If injury

1. When did the patient suffer the injury?

2. What were the circumstances surrounding the injury?

If disability

1. Patient's occupation?

2 When did the patient stop working due to the injury?

3. If patient still disabled, when will the patient be able to commence any type of employment?

a) some duties b) full duties

4. If patient has recovered, when was the patient able to resume.

a) some duties b) full duties

Treatment of present condition

1. When were you consulted?

a) initially? | b) most recently?

2. How often has the patient consulted you?

3. Was the patient admitted to hospital? Yes ☐ No ☐

If yes please advise Hospital Name

Address

Period of admission From to

4. Was confinement in a convalescent home necessary after hospitalisation? Yes ☐ No ☐

If yes please give details.

5. What are the current subjective symptoms.

6. Please give results of any objective findings.

a) X-rays

b) Other test - Please advise test done and findings

7. What surgical procedures have been performed?

8. What surgical procedures have been contemplated?

9. What other treatment has the patient undergone?

10. What other treatment is required?

Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐

If yes please advise nature of underlying conditions and how they affect current disability and recovery.

Has the patient any other physical or mental impairment? Yes ☐ No ☐

If yes, please describe.

Please advise names and addresses of other treating physicians.

Name	Address	Telephone

If you have terminated treatment, please advise date.

What is your current prognosis?

Are there any further remarks which may assist in assessing this condition?

Treatment of present condition

Is there any permanent disability present? Yes ☐ No ☐

If yes, please explain giving estimated percentage of loss of function.

Name (please print name):	Address:	Telephone:

Signature:	Professional qualifications:	Date:

Privacy consent notice

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at www.qbe.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting,disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Claim declaration and authorisation

The information and answers given above are true, correct and complete in every detail.

1. I understand the claim may be refused if information is not true or withheld.
2. I authorise Cunningham Lindsey Australia Pty Ltd as agents for QBE to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.
3. 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.

Medical Authority: I authorise any hospital, physician or other person who attended me, to give Cunningham Lindsey Australia Pty Ltd as agents for QBE or its representatives any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature of player (or parent/guardian if under 18 years of age)

Date

Please print name*:

Please check that this form has been fully completed as any omissions may delay your claim.