Sports insurance claim form

Harness Racing

Harness Racing
NEW SOUTH WALES

Arthur J. Gallagher
BUSINESS WITHOUT BARRIERS™

1. Please complete Parts 1 - 8 of this claim form (pages 2 - 4), plus the injury data collection questions on pages 5 and 6
2. Ask your doctor to complete the 'Medical Statement' (pages 7 - 9)
3. To lodge a loss of earnings claim for review (if applicable), follow the below steps, coverage to be determined once all relevant information received:
   (a) Ask your employer to complete Part 9. If you are self-employed please have your accountant complete these details
   (b) Forward a medical certificate every four weeks if your disability is continuing
4. An authorised official of your club must complete Part 10 (page 5)
5. Please refer to 'Notes for claimants' on page 12
6. To maximise claims handling efficiency send your completed claim form to Arthur J Gallagher Brisbane office. Refer to the bottom of page 12 for the Brisbane office address.

1: The policy holder

Name:_____

Club: _____

2: The Member

Name:_____

Address: _____

_____State:_____Postcode: _____

Phone: (Work): _____Mobile:_____

Email Address:_____

Occupation: _____

Date of Birth: ___ / ___ / ___ Sex: ☐ Male ☐ Female

Licence Number (if known):_____

Your Australian Tax File Number: _____

Your Australian Tax File Number will be kept safe and secure and only used for tax related purposes. If you do not wish to provide your Tax File Number, we will then have to apply the highest applicable tax rate to any taxable benefits paid to you for this claim.

3: Details of the Member's Disability or Injury

What is the nature of **Your** injury? _____

What body part/s has been injured? _____

Is it a recurrence of a previous injury? ☐ Y ☐ N

How did it happen?_____

_____

_____

Address where it happened? _____

_____

Type of location: Public Race Track ☐ Training Track ☐ Stables Owner/Trainers property ☐ Other ☐

If 'Other' please describe:_____

3: Details of the Member's Disability or Injury (continued)

When did the injury occur? ___ / ___ / ___ Time: _____

What were **You** doing? Driving Gig ☐ Riding On Back of Horse ☐ Attending to Horse ☐

Loading/Unloading Horse from Trailer ☐ Other ☐

If 'Other' please describe:_____

What was the event? Official Race ☐ Trial ☐ Private Training ☐ Trackwork Training ☐ Other ☐

If 'Other' please describe:_____

4: Details of the Member's treatment

Name and address of each hospital **You** attended:_____

_____

Date of: Admission: ___ / ___ / ___ Discharge: ___ / ___ / ___

Name, address and phone numbers of all attending doctors: _____

_____

_____

_____

Name, address and phone number of **Your** usual doctor_____

_____

_____State:_____Postcode: _____

5: Details of the Member's previous Disabilities, injuries or claims

Were **You** suffering any previous medical condition? ☐ Y ☐ N

If 'Yes', give details of the condition:_____

_____

_____

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? ☐ Y ☐ N

If 'Yes', what was the date of injury ___ / ___ / ___

Who was the insurer?_____

How much were **You** paid?_____

What was the injury?_____

Name and address of the doctor: _____

_____State:_____Postcode: _____

6: Details of the Member's insurance

Are **You** a member of a health fund? ☐ Y ☐ N

If 'Yes', what type of membership ☐ Hospital cover only ☐ Ancillary cover only ☐ Hospital plus ancillary benefits do **You** have?

Name of health fund: _____

Membership number: _____

Any other details regarding private health cover: _____

_____

Do **You** have any other insurance to cover this disability or Injury? ☐ Y ☐ N

If 'Yes', please show name and address of insurer _____

_____ State: _____ Postcode: _____

7: Drugs and intoxicating liquor

Were **You** under the influence of any drug or intoxicating liquor when the disability or injury took place ☐ Y ☐ N

If 'Yes", please give details: _____

_____

Have **You** taken any performance enhancing drugs? ☐ Y ☐ N

8: The Member's declaration

By signing this claim form I declare that:

a) I hereby authorise any hospital, physician, insurer, health insurance commission, employer or other person who has attended me to supply Lumley Insurance or its representative with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all my hospital and/or medical records, including any and all relevant financial information and details of any paid entitlements with respect to the claimed injury or sickness.

b) I agree that a photostat and/or facsimile copy of this authorisation shall be considered as effective and valid as the original.

c) 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 claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery there under or in respect of past or future claims shall be forfeited.

Must be completed by the injured **Member** or their guardian if the member is under 18 years

Signature: _____ Date: ___ / ___ / ___

9: The Member's employment details (Must be completed by pay clerk/paymaster)

Employer's name: _____

Employer's address: _____

_____ State: _____ Postcode: _____

Phone number: _____

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury. *(Excluding bonuses, commissions, overtime or any other allowances)* $ _____

Date **You** expect **Your** employee to resume work ___ / ___ / ___

Date **You** expect **Your** employee to resume normal duties (fully fit) ___ / ___ / ___

What is **Your** employee's gross annual salary? $ _____

What date did he or she commence employment? ___ / ___ / ___

9: The Member's employment details (continued)

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury
(net of business expenses, but before income tax and personal deductions e.g. Tax Return)

What is the name of **Your** pay clerk? _____

What is **Your** pay clerk's phone number? _____

Signature of pay clerk / paymaster: _____ Date: ___ / ___ / ___

10: Harness Racing NSW declaration (completed by Club Secretary or Treasurer)

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

I _____*NSWHR employee*

Confirm that (*Name of Member and Licence Number)*_____

Sustained the injuries resulting in this claim on:

_____*Date* at _____*Time*

While (description of activities) _____

_____

At (place)_____

The first consultation with a doctor for this injury was on:

_____*Date*

at _____*Address of doctor*

Signature: _____Date: ___ / ___ / ___

Mailing address: _____

_____State:_____Postcode: _____

Phone number: _____

11: Electronic Funds Transfer (completed by injured person)

I/We hereby authorise that all future payments be made via Electronic Funds Transfer to the following bank account:

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Bank Name: _____

Branch Address: _____

Account in the Name of: _____

Type of Account: _____

BSB Number:

			–			

(6 digits)

Account Number: _____

Conditions of this agreement:

- I/We will be responsible for notifying Arthur J. Gallagher in writing of any changes in the above particulars. Until receipt of such notifications, Arthur J. Gallagher shall process all payments in accordance with the above particulars.
- I/We warrant that the bank account details so provided are not false and comply with all applicable laws.
- Arthur J. Gallagher has the right to accept the authority of the undersigned as conclusive evidence of that persons authority to execute this agreement on behalf of the supplier. Arthur J. Gallagher is under no obligation to verify the authority of the undersigned on the Bank Account details.
- I/We acknowledge that it is not practicable for Arthur J. Gallagher to keep banking details confidential, to the extent that these will be available to Arthur J. Gallagher in carrying out their normal duties in paying accounts.
- Arthur J. Gallagher will not be responsible for any delays in the payment of errors due to factors outside the reasonable control of Arthur J. Gallagher (including but not limited to delays and errors in the banking system).
- Arthur J. Gallagher reserves the right at any time to terminate or suspend this direct credit payment metod and to pay by cheque or any other manner which Arthur J. Gallagher may determine.

Name (please print): _____

Signature: _____ Date: _____ / _____ / _____

PERSONAL INFORMATION PROTECTION STATEMENT

Personal information we collect from you on this Electronic Funds Transfer Form will be used by Arthur J. Gallagher staff for the purpose of making payments to you in respect of your claim. Your personal information will be used for the primary purpose for which it is collected, and will not be disclosed to third parties. Your personal information will be managed in accordance with the National Privacy and Data Protection Act 2014.

Injury data collection

Arthur J. Gallagher is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. Arthur J. Gallagher, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was Your role at the time of Your injury?
☐ Driver ☐ Licenced trainer ☐ Stable hand ☐ Other

If 'Other' please provide details: _____

If incident occurred at Public Race Track, where did it occur?
☐ Loading/Unloading Horse ☐ Stable ☐ On Track
☐ Marshalling Area ☐ Parade Ring ☐ Other

If 'Other' please provide details: _____

If incident occurred at owners/trainers property, where did it occur?
☐ Loading/Unloading Horse ☐ Paddock ☐ Stables
☐ On training track ☐ Other

If 'Other' please provide details: _____

On what surface did the incident take place?
☐ Sand ☐ Grass ☐ Bare dirt ☐ Gravel
☐ Concrete / Bitumen ☐ other

If 'Other' please provide details: _____

What was the condition of the surface?
☐ Normal ☐ Soft ☐ Hard ☐ Other

If 'Other' please provide details: _____

What were the weather conditions as the time of injury?
☐ Fine ☐ Light Rain ☐ Heavy Rain ☐ Other

If 'Other' please provide details: _____

What were the temperature conditions as the time of injury?
☐ Very Hot ☐ Hot ☐ Hot & Humid ☐ Mild
☐ Cold ☐ Very Cold ☐ Other

If 'Other' please provide details: _____

How was the onset of injury?
☐ Sudden ☐ Gradual ☐ Pre-Existing at the start of the activity

If you personally collided with/were struck by something, what was it?
☐ Own Horse ☐ Another Horse ☐ Ground / Track ☐ Gig
☐ Fence ☐ other

If 'Other', please describe _____

What protective equipment was being worn at the time of the injury?
☐ None ☐ Helmet ☐ Safety Vest ☐ other

If 'Other', please describe _____

How did the injury severity affect the activity you were involved in at the time?
☐ Unable to continue ☐ Continued after treatment
☐ Continued to participate without treatment

What was the immediate treatment? (more than one box may be ticked)
☐ Rest ☐ Ice ☐ Compression ☐ Elevation
☐ Stretching ☐ Mobilisation ☐ Taping ☐ Bandaging
☐ Sling ☐ Splint ☐ Other ☐ Unknown

If 'Other' please provide details: _____

Were first aid / medical personnel present at the activity?
☐ Yes ☐ No ☐ Unknown

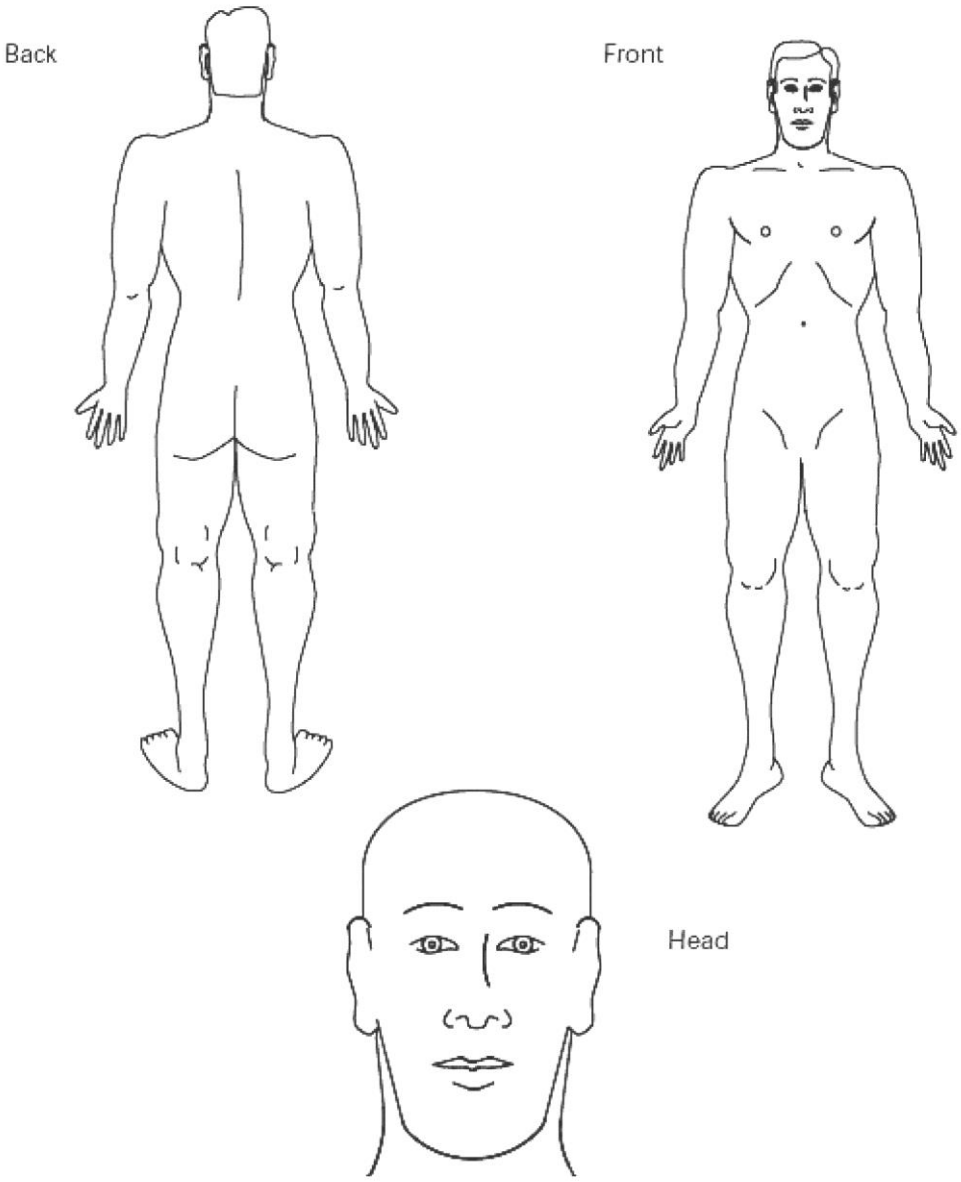
If Your injury required referral, to whom were You referred? ☐ Hospital ☐ Doctor ☐ Physiotherapist ☐ Dentist ☐ Other

If 'Other' please provide details: _____

If immediate off site treatment was necessary, what mode of transport was used? ☐ Ambulance ☐ Private Vehicle ☐ Other

If 'Other' please provide details: _____

Please indicate the site of your injury on the appropriate diagram below:



Medical statement

This form must be completed by the registered medical doctor treating the injury

The claimant is responsible for any fee for this statement.

The policy holder

The policy holder: _____

Club name: _____

The Member

Name:_____

Address: _____State:_____Postcode: _____

Date of Birth: ___ / ___ / ___ Sex: ☐ Male ☐ Female

The injury

Complete Diagnosis _____

_____

_____

_____

History

When did the present disability or injury occur? ___ / ___ / ___

Date the participant ceased work: ___ / ___ / ___

Is there a history of the same or similar condition?_____

Is this a recurrence? ☐ Y ☐ N

Present condition

Subjective symptoms:_____

_____

Objective finding *(give reports of any x-rays, ECGs or other tests)*_____

_____

_____

_____

Is the player ☐ Walking ☐ Bed confined ☐ House confined ☐ Hospital confined

Date of admission: ___ / ___ / ___

Treatment of present condition

Date of first consultation: ___ / ___ / ___

Date of latest consultation: ___ / ___ / ___

Frequency of consultations: _____

Date of last hospitalisation: ___ / ___ / ___

Name of hospital:_____

Nature of surgical procedure: _____

_____ _ ☐ Contemplated ☐ Performed

Progress

If performed: ___ / ___ / ___ Has condition improved? ☐ Y ☐ N

If 'No', please explain: _____

Degree of disability

Has the patient been able to do any work? _____

If 'No', from what date Regular work: ___ / ___ / ___ Light duties: ___ / ___ / ___

When will the patient be able to resume for Regular work: ___ / ___ / ___ Light duties: ___ / ___ / ___

Other treatment

If the patient was seen in consultation by another doctor, please give the date, ___ / ___ / ___
name and address of that doctor

_____

_____State:_____Postcode: _____

If the patient is no longer under your care, what date were your services terminated? ___ / ___ / ___

Other conditions

Describe any other disease or infirmity affecting the patient's present condition: _____

_____

_____

_____

Please complete the appropriate section if the disability or injury is due to:

Cardiac-circulatory

Blood pressure:_____

Circulatory disorder – please describe: _____

_____

_____

Visual

Is the patient totally or industrially blind? ☐ Y ☐ N

If 'No', what was the vision at
last observation: With glasses: ☐ Distant ☐ Near Date: ___ / ___ / ___

Without glasses: ☐ Distant ☐ Near Date: ___ / ___ / ___

What is the extent of any gross visual field defect? _____

Could vision be improved by treatment, surgery or lenses? ☐ Y ☐ N

What are the rehabilitation prospects? _____

_____

_____

Orthopaedic

Please report findings of specialist if referred?_____

_____

_____

Neurological

Please report findings of specialist if referred?_____

_____

_____

Prognosis

_____

_____

Remarks

_____

_____

Signature: _____ Date: ___ / ___ / ___

Degree: _____

Name of Doctor

(please print): _____

Address: _____

_____

_____Postcode: _____

Please apply doctors name stamp below

Notes for claimants

Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

Loss of income claim (if eligible)

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete**
2. **Please forward your completed Sports Injury Claim Form to our office within 30 days of your injury. Do no wait for all your medical accounts. Forward them to us as you receive them.**

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for Arthur J. Gallagher & Co (Aus) Limited The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer your complaint to the Insurance Broking Division of the Financial Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the Arthur J. Gallagher web site at **www.ajg.com.au** or telephone 1800 240 432.

Claims Handling

Claims are processed at Arthur J. Gallagher Brisbane office (refer Brisbane address below). To maximize claims handling efficiency send your completed claim form and documentation direct to that office.

Brisbane claims
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