

CYCLING AUSTRALIA AND BMX AUSTRALIA



PERSONAL INJURY CLAIM FORM

INSURANCE BROKER FOR CYCLING AUSTRALIA AND BMX AUSTRALIA

Willis Australia Limited
HEAD OFFICE
Level 5, 179 Elizabeth Street, SYDNEY NSW 2000
Phone (02) 9285 4111
or
local call cost only 1300 WILLIS (i.e 1300 945 547)
Fax (02) 9283 5276
Email: sports.au@willis.com
Website: www.willis.com.au

CYCLING AUSTRALIA & BMX AUSTRALIA

SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Injury. The scale of benefits is defined in the policy. \$50,000 For Seniors (Whilst Competing in a sanctioned event), \$10,000 For Seniors (Whilst involved in official training), \$5,000 For Juniors (Whilst involved in official training), \$100,000 Quadriplegia & Paraplegia. The Death Benefit is reduced to \$10,000 for any Insured Person under the age of 18 or over the age of 65.

Non Medicare Medical Expenses

Reimburses up to 80% of Non-Medicare medical expenses up to a maximum of \$3,000. Claimable expenses are physiotherapy, private hospital, ambulance, dental etc, net of any recoveries from private health insurance, subject to a \$50 excess, unless if they are in a Health Fund in which case the excess drops to nil. Cover is limited to expenses incurred within 12 months from the date of injury.

Loss of Income

Event 18 – Income Earners (Temporary Total Disablement caused by Injury)

We will pay up to 75% of the actual loss of or reduction in Income or \$500 per week whichever is the lesser while the Insured Person suffers Temporary Total Disablement after the end of the Deferral Period. This applies only where, immediately prior to Injury the Insured Person earned an Income. Benefit Period up to 52 weeks each and every claim with a 14 days Deferral each and every claim

Event 19 – Non-Income Earners

We will pay up to 100% of the actual cost of home help from a recognised & licensed domestic help agency certified as necessary for the duration of the Temporary Total Disablement by a Medical Practitioner or \$200p/w whichever is the lesser. Benefit Period up to 52 weeks each and every claim with a 7 days Deferral each and every claim

Event 20 – Full Time Students

We will pay up to 85% of the actual cost of home tutorial by a qualified tutor certified as necessary for the duration of the Temporary Total Disablement by a Medical Practitioner or \$200p/w whichever is the lesser. Benefit Period up to 52 weeks each and every claim with a 7 days Deferral each and every claim.

Inconvenience Allowance

We will pay up to 100% of eligible expenses up to \$1,500 for any one Insured person for reimbursement of reasonable travelling or personal expenses necessarily incurred as a result of an injury to an Insured Person in the transportation of the Insured Person to a hospital or place of treatment or in the emergency attendance on the Insured Persons parents, guardian, spouse, partner or children.

Important Notes

This insurance cover is underwritten by:-

SLE Worldwide Australia Pty Limited
ABN 15 066 698 575
Level 23, Darling Park Tower 2
201 Sussex Street
Sydney NSW 2000
AFL Licence No. 237268

1. This information is only a summary of the cover provided. The policy with full conditions are available by contacting Cycling Australia & BMX Australia.
2. This insurance program commenced on 30th November 2008 and expires on 30th November 2009.
3. Willis Australia Limited has arranged this insurance program to provide benefits to those registered members of Cycling Australia & BMX Australia. 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 this policy all members and officials are encouraged to take out private health insurance.
4. Cycling Australia & BMX Australia are not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

HOW TO MAKE A CLAIM

Dear Cycling Australia & BMX Australia 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 and sign and date the Declaration.
3. Please ensure that your Club official completes and signs the Club Declaration on page 4.
4. For claims involving Loss of Income:-
 - a) You must complete page 6 and have your employer/salary officer to complete page 6. If self employed, you must have your accountant complete these details;
 - b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 8.
5. For claims involving Non-Medicare medical expenses:-

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a medical practitioner or dentist).

 - a) Have your Attending Physician complete the "Attending Physician" statement on page 8.
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 Australian Health Insurance Act does not permit us 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, remedial massage (must be a registered provider) 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. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to Cycling Australia & BMX Australia, PO Box 7183, BASS HILL, NSW.2197.
8. Cycling Australia or BMX Australia will verify your membership and sign the statement on page 4 and forward your claim onto Willis – Level 5, 179 Elizabeth Street, SYDNEY NSW 2000. Willis will then send the documentation to SLE Worldwide Australia Pty Limited. Your reimbursement cheque or payment via electronic banking into your nominated banking institution will be sent to you directly by SLE Worldwide Australia Pty Limited.
9. **Once your claim is registered, you can submit ongoing invoices via SLE Worldwide Australia Pty Limited – Level 23, Darling Park Tower 2, 201 Sussex Street, SYDNEY, NSW. 2000 SLE Worldwide Australia Pty Limited can also be reached on ph: (02) 9249 4850 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, please do not hesitate to call the Willis Sports Team on (02) 9285 4111 or local call cost only 1300 WILLIS (i.e 1300 945 547).

Office use only

Claim Number:.....

PERSONAL ACCIDENT CLAIM FORM

MEMBER DETAILS

	Member No (if applicable):	Given Name: Surname:
Gender (please tick): ★ Male ★ Female	Occupation:	Date of Birth: / /
Address	State Postcode	Email:
Phone Number (work): ()	Home ()	Mobile

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I _____ (insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise the insurer, underwritten for certain underwriters at Lloyds of London by their agent by SLE Worldwide Australia Pty Limited to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by the insurer, underwritten for certain underwriters at Lloyds of London by their agent by SLE Worldwide Australia Pty Limited and their service providers in order to assess the claim. The insurer, underwritten for certain underwriters at Lloyds of London by their agent by SLE Worldwide Australia Pty Limited complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Declared at _____ In the State/Territory of _____

Signature of Claimant (or Legal Guardian _____ Date _____
if under 18 years of age)

DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: ()
Address	State Postcode

I, the above mentioned Cycling Australia or BMX Australia official, confirm that the claimant was a registered and financial member of this Cycling Australia or BMX Australia club and was an insured person as identified in the Personal Accident Insurance with SLE Worldwide Australia Pty Limited at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Dated: / /	Signature of Club Official:
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STATEMENT BY CYCLING AUSTRALIA & BMX AUSTRALIA.

I confirm that the above named claimant nominated on this claim form is a paid registered insurance member of the Cycling Australia or BMX Australia Personal Accident Insurance Program.

Name of State/Territory:	Date: / /
Official's Name:	Signature:

ACCIDENT DETAILS

Describe the accident and how it happened?

Describe your injury?

When did your accident occur?

Date: / / Time: am/pm

Please provide the address of where the injury occurred?

State the name of a 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 the 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?

Do you have Private Health Insurance?

If yes, please give fund name?

Advise when you did (or expect to):

Cease work/normal activities _____
 Cease training _____
 Cease participating _____
 Resume work/normal activities _____
 Resume training _____
 Resume participating _____

Have you ever had this injury or similar injuries in the past?

If yes, please advise when?

 / /

Please tick the category applicable

Cyclist ()
 Official ()
 Coach ()
 Other ()

Was your activity at the time of the accident?
 (please tick)

Sanctioned club/state/national competition ()
 Sanctioned club/state/national training ()
 Logged training ()
 Travelling to and from activity ()
 Sanctioned fundraising/social event ()

LOSS OF INCOME

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(please tick the box)	Yes	No
1. Can compensation be claimed under worker's compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER/SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

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: Net \$..... Gross \$..... <small>If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.</small>	Date commenced employment with company: / /	
Income Definition: * Self Employed * Full Time * Part Time * Casual		
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/...../.....
Has the employee returned to work?		* Yes * No
Has the employee lodged or intending to lodge a Workers Compensation Claim?		* Yes * No

A. IF EMPLOYED

Salary officers name:	Phone Number: ()
Salary officers signature:	Date: ABN/ACN: / /

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ()
Accountant's signature:	Date: / /

Office use only
 Claim Number:.....

Willis Australia Limited
 ABN 90 000 321 237 AFS 240600



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SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT

(PLEASE PRINT LEGIBLY)

IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist)
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 PHYSICIAN

Patient's Full Name:

How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?

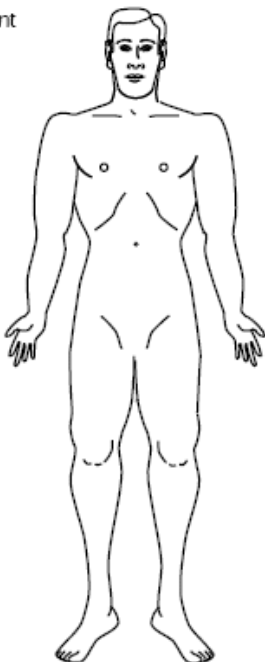
/ /

Are you the patient's regular general practitioner? * Yes * No

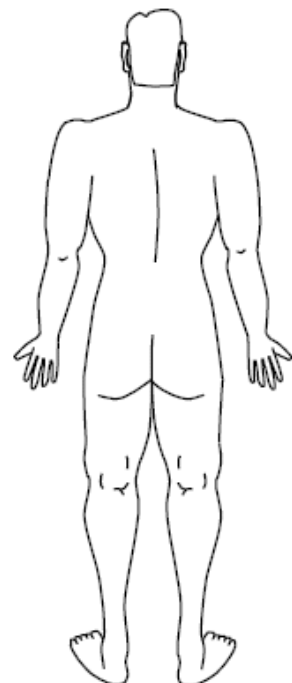
If not, please advise who is

What is the exact nature of the present injury?

Front



Back



Head

