JLT Sport Personal Injury Claim Form

Northern NSW Football 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 NNSWF Risk Protection Programme; and
- ☑ **Injured -** You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned football 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/NNSWF .

What is covered?

The NNSWF Risk Protection Programme's Personal Accident cover provides some reimbursement for Non-Medicare Medical Costs and/or Loss of Income cover for 12 months from the date of injury.

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).

How much can I claim?

The following table outlines the reimbursement capacity within the NNSWF Risk Protection Programme.

Non-Medicare Medical Costs	Loss of Income
85% Reimbursement	85% Reimbursement
$5,000 maximum per claim / $350 maximum for Physio	$300 maximum per week
$50 excess per claim	14 day waiting period

All clubs receive the above coverage at the commencement of each period of cover.

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 NNSWF 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.

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:

QBE Claims Department

GPO Box 4108

Sydney NSW, 2001

Or

accidentandhealth@qbe.com

www.jltsport.com.au

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Section A: Claimant's Details

How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
   - Your claim form may be returned if there is important information missing
   - For assistance, please contact your QBE Claims team; **02 9375 4874**
   - Send your completed claim form to QBE Claims Department – GPO Box 4108, Sydney NSW 2001 or accidentandhealth@qbe.com.

Please note; email is the most efficient method of claim lodgement

2. Within 90 days from the date of injury.
   - ***Do not*** wait until your treatments have concluded before you lodge your claim
   - You can lodge your claim even if you have no out of pocket expenses
3. QBE 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 QBE 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 QBE.

Retain a copy - Please submit only original receipts to QBE. 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 QBE 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 QBE within 180 days from the date of injury.

Subject to 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 QBE must be provided by you upon request and at your expense (if applicable).

Who is JLT Sport?

JLT Sport is the appointed broker for the NNSWF 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 the Privacy Act 1988:

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) 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 or risk management (depending on your requirements). Other purposes include providing you with information about other JLT products or services. 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 JLT related Group companies. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- By providing the information requested in the attached document, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- If you do not provide all or part of the information requested, we may be unable to process your application or provide other required services, your application for insurance may be declined or you may prejudice your insurance cover.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided, as they occur.
- 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.

For further information contact your JLT Client Risk Adviser or the JLT Privacy Officer:
Jardine Lloyd Thompson Pty Ltd, 66 Clarence Street, SYDNEY NSW 2000 Telephone: (02) 9290 8000

PERSONAL INFORMATION:

Claimant's Name: _____ _____

First Name Surname

Complete ALL sections

Send within 180 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

Send completed forms to:

QBE Claims Department

GPO Box 4108

Sydney NSW, 2001

Or

accidentandhealth@qbe.com

www.jltsport.com.au

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Section A: Claimant's Details

Postal Address: _____
Street Address | State | Postcode

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

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

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

Location: ○ Indoor ○ Outdoor

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

Grade: ○ Senior ○ Junior ○ Not Applicable

Surface Type: ○ Asphalt ○ Concrete ○ Grass ○ Indoor ○ Timber ○ Synthetic Grass

Weather Conditions: ○ Fine ○ Rain ○ Extreme Heat ○ Extreme Cold

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:

Payee details: ○ Myself ○ Other _____ _____
To whom should we make payment? | BSB | Account Number

_____
Account Name

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/NNSWF.
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 and the Claims Managers.
E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish QBE'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

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accidentandhealth@qbe.com

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Section B: Association Declaration

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: _____

INJURY DETAILS:

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

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 / /

Is the player registered? ○ Yes ○ No Registration number: _____

CLUB DECLARATION:

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

A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or League (as above).
B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
C. You declare the Claimant's injury was sustained accidentally during the football activity noted above and is not a pre-existing illness or condition.

Club Representative's Signature: _____ Date: / /

ASSOCIATION DECLARATION:

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

D. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).
E. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
F. You declare the Claimant's injury was sustained accidentally during the football activity noted above and is not a pre-existing illness or condition.

Association Representative's Signature: _____ Date: / /

Association Name and Title _____

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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.

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)*

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

www.jltsport.com.au/NNSWF

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Section D: Physician's Report

This section must be completed (in full) by your attending Dentist, Doctor or Surgeon not by a physiotherapist or chiropractor.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

PHYSICIAN'S REPORT

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

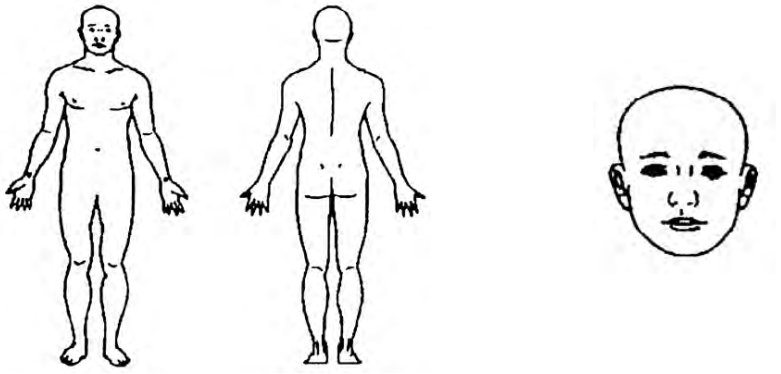
Physician's Details: _____ (Physician's Name) _____ (Phone Number)

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

Please mark (×) the anatomical location below:



Injury Type: ○ Amputation ○ Bruising ○ Concussion ○ Cut ○ Death ○ Dental ○ Dislocation ○ Fracture/Break ○ Rupture ○ Sprain ○ Strain ○ 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 a recurrence of a previous injury? ○ Yes ○ No

If YES, please provide details and a description:

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:

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