

# AUSTRALIAN LITTLE ATHLETICS



# PERSONAL INJURY CLAIM FORM

Willis Australia Limited  
HEAD OFFICE  
Level 8, 2 Market 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](mailto:sports.au@willis.com)  
Website: [www.willis.com.au](http://www.willis.com.au)

# AUSTRALIAN LITTLE ATHLETICS 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 \$150,000 (other than anyone under 18 years old \$20,000 maximum). The paraplegia and quadriplegia benefit is \$250,000.

## Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$10,000. Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance – subject to an \$50.00 excess. Cover is limited to expenses incurred within 12 months from the date of injury.

## Student Assistance Benefit

Reimburses up to 100% of costs incurred up to a maximum of \$500 per week for up to hundred and four (104) weeks being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student – 7 day excess.

## Household Help Allowance

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of \$500 per week for up to hundred and four (104) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy – 7 day excess.

## Bed Care Benefit

Is payable as a result of an accident you are confined to a bed for not less than 48 hours under the direction of a Doctor. Benefits payable \$50 per day for a maximum of 20 days.

## Loss of Income

Cover for 80% of your net weekly income or up to a maximum of \$1,000 per week, whichever is the lesser. The benefit period is 104 weeks and the excess is 7 days.

## Important Notes

This insurance cover is underwritten by:- ACE Insurance Limited ABN: 23 001 642 020  
28-34 O'Connell Street  
SYDNEY NSW 2000

1. This information is only a summary of the cover provided. The policy with full conditions is available by contacting Australian Little Athletics.
2. This insurance program commences on 30 September 2006 and expires on 30 September 2007.
3. Willis Australia Limited has arranged this insurance program to provide benefits to those registered members of Australian Little Athletics 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.
4. Australian Little Athletics is 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 Australian Little Athletics member,

Please find enclosed 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 Centre and State Association completes and signs the Centre/State 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 general practitioner, physiotherapist, chiropractor, 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, 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.

7. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to your State Association.
8. Your State Association will verify your membership and sign the statement on page 4 of the claim form. They will forward your completed claim form and relating documentation directly to Willis Australia who will then send the documentation to ACE Insurance Limited. Your reimbursement cheque will be sent to you directly by ACE Insurance Limited.
9. If you have any further queries relating to your claim, please do not hesitate to call the Willis Sports Team on (02) 9285 4111 or 1300 WILLIS (1300 945 547).

## PERSONAL ACCIDENT CLAIM FORM

### CLAIMANT DETAILS

Name of Centre:	Member No:	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 ACE Insurance 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 ACE Insurance Limited and their service providers in order to assess the claim. ACE Insurance 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 AUSTRALIAN LITTLE ATHLETICS CENTRE

Name of Centre:	Name of Club Official making this statement:
Official Position:	Telephone Number: ( )
Address	State      Postcode
I, the above mentioned Australian Little Athletics official, confirm that the claimant was a registered and Financial member of this Australian Little Athletics Centre and was an insured person as identified in the Personal Accident Insurance with Australian Little Athletics 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:

### STATEMENT BY AUSTRALIAN LITTLE ATHLETICS STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered insurance member of the Australian Little Athletics Personal Accident Insurance Program.

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



## 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).</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?

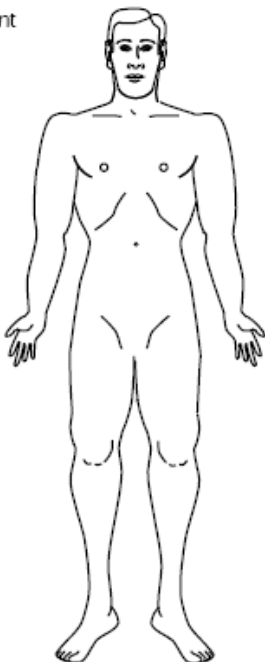
/ /

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

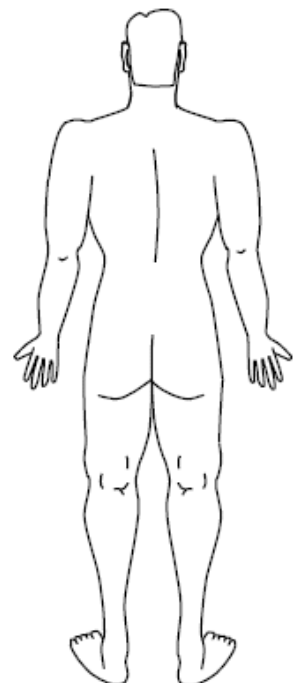
If not, please advise who is .....

What is the exact nature of the present injury?

Front



Back



Head

