QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Football Sporting Accident Claim

Claiming Notes:

- **The issue of this form does not constitute an admission of liability on the part of the insurer.**
- **Do not wait for your accounts before sending claim.**
- **Continue your treatment and forward ORIGINAL itemised accounts and receipts.**
- **Claims without referral from a medical practitioner or dentist following injury will be denied.**
- **Government legislation does not allow us to refund any part of an account which can be claimed in part through Medicare. DO NOT SEND ANY MEDICARE ACCOUNTS.**
- **Please complete this claim and forward to the address shown below within 60 days of injury.**

Send fully completed form to:

QBE Insurance (Australia) Limited
GPO Box 4108
Sydney NSW 2001

Contact Phone No. (02) 8275 9174 Fax No. (02) 8275 9650

Player Details

Name	Surname	Given Name(s)	
Are you registered for GST?	No ☐ Yes ☐	What is your ABN?	
1. Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	Yes ☐ No ☐ If "No", go to question 3		
2. Will you be claiming an amount less than 100%?	No ☐ Yes ☐ – Specify amount claimed		%
3. Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	Yes ☐ No ☐ If "No", go to Address		
4. Will you be claiming an amount less than 100%?	No ☐ Yes ☐ If "Yes", specify amount claimed		%
Address		State	Postcode
Contact numbers	Home	Work	( )
	Mobile	Email	
Occupation		Sex M ☐ F ☐	Date of Birth / /
Sport		Club/Team	
Association/League		Registration No. (if applicable)	
Name of payee		Relationship	

Injury Details

Date of Injury	/ /	Time of Injury	am/pm
Were you:	Playing ☐	Training ☐	Travelling ☐ Winter Comp ☐ Summer Comp ☐
Type of injury			
How did injury occur:	Collision ☐	Tripped ☐	Fell ☐ Other ☐ give details
Have you suffered this injury or similar injury in the past	No ☐ Yes ☐	If 'Yes' give details	
Are you entitled to claim under any other personal accident policy or social security for this injury?	No ☐ Yes ☐		

Health Fund Membership

If you are a member of a Private Fund, you MUST claim on your fund first. Please forward fund statements with this claim.

Are you a member of a Private Health fund?	No ☐ Yes ☐	Membership Number	
Name of Fund			
Have you elected Extra Cover i.e. Physio/Chiro/Dental?	No ☐ Yes ☐		
Have you elected Hospital and Ambulance Cover?	No ☐ Yes ☐		

Privacy

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the ***QBE Privacy Policy Statement*** from our website **www.qbe.com.au** or contact the Compliance Manager on 02 9375 4656 or email **compliance.manager@qbe.com** for further information.

Injured Player's Authorisation and Declaration

I hereby authorise any hospital, physician or other person who has attended me or any employer and the Department of Social Security, to furnish QBE or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatment, copies of all hospital medical records and copies of all records of employers. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

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

I understand the claim may be refused or reduced if information is withheld.

I authorise that QBE 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.

I have read and understand the information sheet that tells me what I am covered for by this Policy.

Signature of Injured Player X Date / /

DELAYS IN SEEKING MEDICAL ADVICE AND THE IMMEDIATE COMMENCEMENT OF RECOMMENDED TREATMENT COULD PREJUDICE YOUR ENTITLEMENT UNDER THE POLICY

Income and Employment Details - For Employees

Employer					
Address		State		Postcode	
Date commenced with employer	/ /	Date ceased work due to injury	/ /		
Expected resumption date	/ /				
Gross weekly income prior to injury	$	Gross annual income	$		
Details of payments during time off work (ie Holiday/Sick leave)					
Paid from	/ /	to	/ /		
Salary Officer's Name		Telephone No.	( )		
Salary Officer's Signature	X	Date	/ /		

Income and Employment Details – for Self-Employed persons

You must provide all the details above on a Statutory Declaration and have it signed and witnessed by a Justice of the Peace. You must also advise on the Statutory Declaration whether or not you have any other Personal Accident or Income Protection policy that you can claim on for this injury. If you do, you should advise the name of the Insurer and contact phone number, policy number, sum insured per week or per month, and the waiting period or excess. You must also send a copy of your last Taxation Assessment Notice and Profit/Loss Statement.

Club Official Declaration

This is a legal document and false declaration can result in legal implications for both the individual and the Club.

I,		of	
Club official of (title)		Club	
Football NSW ☐ Northern NSW Football ☐		Certify that	
		Player	
Sustained injuries resulting in this claim on	/ /	at	am/pm
whilst training/playing at			
Club mailing address		Postcode	
Is the player a registered player No ☐ Yes ☐		Registration No.	
Did the player appear on official team playing sheet? No ☐ Yes ☐		Winter Comp ☐	Summer Comp ☐
Rate: Student ☐ Non student ☐			
Club Official's Signature	X	Date	/ /
Telephone Number Home	( )	Business	( )
Association Representative's Signature	X	Date	/ /
Association Representative's Name and Title			

Physician's Statement

Must be completed by a dentist, doctor or surgeon not by a physiotherapist or chiropractor. Any expense for the completion of this statement can only be met by the patient and not by the Insurer.

Patient's Name _____ _____
Surname Given Name(s)

CONDITION – give a complete diagnosis of this condition

HISTORY

When did the patient first suffer the injury? Date / / Time am/pm

What did the patient tell you were the circumstances surrounding the injury?

When did the patient first receive medical treatment? Date / /

When were you first consulted? Date / / Time am/pm

Was there a previous history of this or a similar condition? No ☐ Yes ☐ – When was treatment given?

Were there any structural deficiencies or weaknesses to this region prior to this injury that directly contributed to this injury? No ☐ Yes ☐

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

If "Yes", advise nature of underlying condition and how it affects disability and recovery:

DEGREE OF DISABILITY

When was the patient obliged to cease work? Date / / Time am/pm

If the patient is still disabled, when will the patient be able to resume;

- one or more of the material tasks of their occupation? Date / /
- all of the tasks of their occupation? Date / /

If the patient has recovered, when was the patient able to resume:

- one or more of the material tasks of their occupation? Date / /
- all of the tasks of their occupation? Date / /

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

Physician's Statement *(continued)*

REFERRAL (Must be completed for supporting services)

Physiotherapy ☐ Chiropractic ☐ Osteopathic ☐ Massage Services ☐ Other

Date Referred / / Number of treatments Number of weeks Review date for further referral for treatment / /

HOSPITAL DETAILS

Was the patient confined to hospital? No ☐ Yes ☐ – Give details

Name of Hospital	Address	Period of Confinement	
		From	To
		/ /	/ /
		/ /	/ /
		/ /	/ /

OTHER DETAILS

What are the current symptoms?

Give results of any objective findings:

X-rays

Other Tests – specify

What surgical procedures have been performed or are being contemplated?

Advise names and addresses of other treating physicians

Name	Address

Have you terminated treatment? No ☐ Yes ☐ – On / /

What is the current prognosis?

Are there any further remarks which may assist us in assessing this condition? No ☐ Yes ☐ – Give details

Doctor's Name Qualifications

Address State Postcode

Telephone ( )

Signature X Date / /