JLT Sport Personal Injury Claim Form

Hockey National 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 Hockey National Risk Protection Programme; and
- ☑ **Injured -** You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned hockey 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/hockey.

What is covered?

The Hockey National 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 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?

Please refer to the Programme Summary available on the JLT Sport website for details about how much you can claim – www.jltsport.com.au/hockey.

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 Hockey National 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:

SPORTSCOVER AUSTRALIA

Locked Bag 6003,

Wheelers Hill, VIC 3150

Or

Fax: (03) 8562 9111

Claims Enquiries:

Phone: 1300 134 956

www.jltsport.com.au

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Claim Conditions

How to lodge a Personal Injury Claim:

1. Notify SPORTSCOVER (within 30 days from the date of your injury) of your intention to lodge a claim.

   Phone: 1300 134 956 / Email: **claims@sportscover.com** / Web: **www.sportscover.com**

2. 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 Sportscover on 1300 134 956
3. Send your completed claim form to Sportscover within 120 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
4. Sportscover will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information
5. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to Sportscover 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 Sportscover.

Retain a copy - Please submit only original receipts to Sportscover. 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 Sportscover 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 Sportscover within 120 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 Sportscover must be provided by you upon request and at your expense (if applicable).

Who is Sportscover?

SPORTSCOVER AUSTRALIA PTY LTD (Sportscover) administers the Personal Accident Policy for the Hockey National Risk Protection Programme (arranged by JLT Sport). Sportscover manages all claims associated with this policy.

Who is JLT Sport?

JLT Sport is the appointed broker for the Hockey National 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

Complete ALL sections

Send within 120 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

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Section A: Claimant's Details

PERSONAL INFORMATION:

Claimant's Name: First Name _____ Surname _____

Postal Address: Street Address _____ State _____ Postcode _____

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

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

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:

EFT Payee Details:

Bank _____ Name on Account _____ BSB _____ Account Number _____

CLAIMANT DECLARATION:

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

A. The injury was sustained accidentally during a hockey 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/hockey.

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 Sportscover'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.

Claimant's Signature* _____ Date: / /

**Parent or Guardian if under 18 years*

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Section B: Club 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 _____ AM PM Time of Injury _____

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 Has the Claimant returned to COMPETITION? / / If YES, date Claimant returned?

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 hockey activity noted above and is not a pre-existing illness or condition.

Club Representative's Signature: _____ Date: / /

WITNESS STATEMENT:

A Statement from anyone who has witnessed your accident is required. Please have a witness provide a full description of the incident giving rise to the claimant's injury, as seen by the witness:

_____

_____

Witness's Name: _____

Witness's Address: _____

Official's Signature: _____ Date: / /

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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)*

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Section D: Physician's Report

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

PHYSICIAN'S REPORT

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

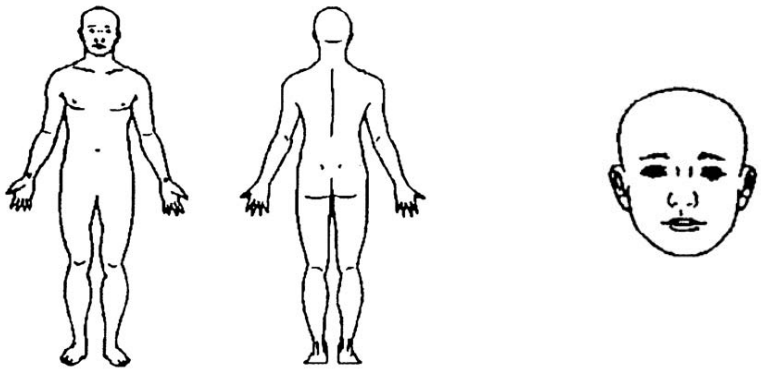
Physician's Details: _____ (Physician's Name) _____ (Phone Number)

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 Hockey? / /

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: / /

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