JLT Sport Personal Injury Claim Form

FFV 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 FFV 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/ffv .

What is covered?

The FFV 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 FFV Risk Protection Programme.

Non-Medicare Medical Costs	Loss of Income
80% Reimbursement	75% Reimbursement
$2,000 maximum per claim	$200 maximum per week
$75 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 FFV 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.

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

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:

SUA Claims Department

PO Box 2717

Taren Point ,NSW 2229

Or

Fax: (02) 9524 9003

Claims Enquiries:

Phone: 1300 363 413

JLT Sport Personal Injury Claim Form

FFV Risk Protection Programme

Claim Conditions

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 Sports Underwriting Australia(SUA) on 1300 363 413.
2. Send your completed claim form to **SUA Claims Department – PO Box 2717, Taren Point, NSW 2229** within 180 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. SUA 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 SUA 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 SUA.

Retain a copy - Please submit only original receipts to SUA. 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 SUA 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 SUA 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 SUA 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 FFV 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

Privacy:

We, JLT (including our subsidiaries and related entities), collect, store and use your personal details in accordance with the Privacy Act 1988 (and subsequent amendments).

We are collecting the information herein principally for the purpose of processing your Personal Injury Claim. Other purposes include providing risk management advice and statistical analyses to your sport.

By providing the information requested in this document, you agree to us collecting, using and disclosing your personal information as outlined in our Collection Statement available via www.jltsport.com.au

If you do not provide all or part of the information requested, we may not be unable to process your application 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 to 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 conditions herein. Where the information relates to health or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent.

Our Privacy Policy is available upon request or you can access it anytime via our web site **www.jltsport.com.au**

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

Complete ALL sections

Send within 180 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

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FFV Risk Protection Programme

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 AM PM 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? ______ Payee Name

______ Payee Postal Address

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/ffv.

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 SUA'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

Important Information

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Section A: Claimant's Details

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www.jltsport.com.au

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Section B: Club Declaration

Important Information

Claim Conditions

Section A: Claimant's Details

Section B: Club Declaration

Section C: Loss of Income

Section D: Physician's Report

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

Club Representative'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)*

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

www.jltsport.com.au/ffv

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Section D: Physician's Report

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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

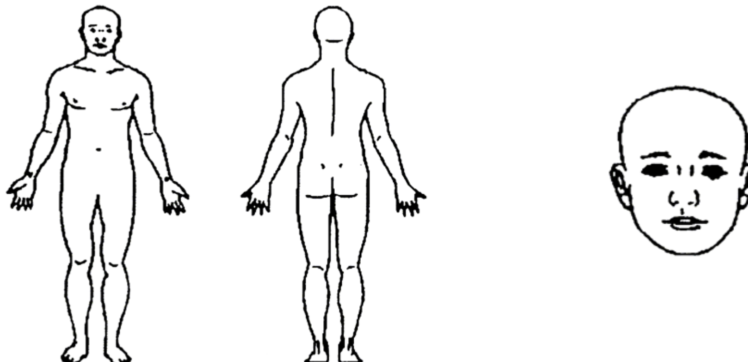
Physician's Details: ______________ Physician's Name ______________ Phone Number

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

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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: / /

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