Australian Fencing Federation Athlete / Member

Sports Injury Rehabilitation Claim Form

Gallagher

AUSTRALIAN FENCING FEDERATION

How to claim

There are a number of important sections for completion and verification by differing experts, please pay attention to each step and call Gallagher claims on 1800 931 129 for any assistance.

1. Complete the Member Injury details section

('Your' relates to you as the registered athlete making the claim)

Pages 3–6

- For claims relating to loss of income, please have your employer complete Section 8, page 5. If you are self-employed please have Your accountant complete these details
- Forward a medical certificate every four weeks if Your disability is continuing

☐ Completed Step 1

2. Have your State Association, to which you are registered to, complete the declaration section

Page 6

☐ Completed Step 2

3. Complete the injury data collection section

(allowing Gallagher and your sporting association to remain proactive in risk prevention and management)

Pages 7–10

- Please ensure the Disclosure Statement and Privacy Consent form, on page 10, have been signed.
- To receive reimbursement via Electronic Banking, please complete Page 11.

☐ Completed Step 3

4. Ask Your treating doctor to complete the 'Athlete injury medical statement'

Pages 12 – 14

☐ Completed Step 4

5. Please refer to 'Notes for claimants' and return all completed sections to:

Pages 15

Email: sport@ajg.com.au

Post:
Gallagher Sporting claims
GPO Box 859, Brisbane, QLD 4001

1. The Association (your state details)

State Association:

Club Name:

Team Name:

2. The Member (Your details)

Name:

Address:

State: Postcode:

Phone: Work: Mobile:

Email Address:

Occupation:

Date of Birth: / /

Sex

☐ Male ☐ Female

3. Details of Your disability or Injury

What is the nature of Your injury?

What body part/s has been injured?

Is it a recurrence of a previous injury?

☐ Yes ☐ No

When did the injury occur? / / Time:

How did it happen?

Where were you when it happened?

Type of location:

☐ Sportsground ☐ Gymnasium ☐ Swimming pool ☐ Other

If 'Other' please describe:

What were You doing?

☐ Playing a match ☐ Warm up ☐ Training ☐ Other sport

If 'Other' please describe:

What was the event?

☐ Competition ☐ Regular training ☐ Training camp ☐ Private training ☐ Other

If 'Other' please describe:

4. Details of Your treatment

Name and address of each hospital You attended:

Date of admission: / / Date of discharge: / /

Name, address and phone numbers of all attending doctors:

Name, address and phone number of Your usual doctor:

State: Postcode:

5. Details of Your previous disabilities, injuries or claims

Were You suffering any previous medical condition?

☐ Yes ☐ No

If 'Yes', give details of the condition:

Have You ever made a claim under a sports' injury or personal accident insurance policy?

☐ Yes ☐ No

If 'Yes', what was the date of injury: / /

Who was the insurer?

How much were You paid?

What was the injury?

Name and address of the doctor:

State: Postcode:

6. Details of Your personal insurance

Are You a member of a health fund?

☐ Yes ☐ No

If 'Yes', what type of membership do You have?

☐ Hospital cover only ☐ Ancillary cover only ☐ Hospital plus ancillary benefits

Name of health fund:

Membership number:

Any other details regarding private health cover:

Do You have any other insurance to cover this disability or Injury?

☐ Yes ☐ No

If 'Yes', please show name and address of insurer:

State: Postcode:

7. Drugs and intoxicating liquor

Were You under the influence of any drug or intoxicating liquor when the disability or injury took place?

☐ Yes ☐ No

If 'Yes", please give details:

Have You taken any performance enhancing drugs?

☐ Yes ☐ No

8. Your employment details

If employed as wage earner

Must be completed by pay clerk/paymaster

Employer's name:

Employer's address:

State: Postcode:

Phone number:

Email:

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury.
(Excluding bonuses, commissions, overtime or any other allowances) $

Date You expect Your employee to resume work: / /

Date You expect Your employee to resume normal duties (fully fit): / /

What is Your employee's gross annual salary? $

What date did he or she commence employment? / /

What is the name of Your pay clerk?

What is Your pay clerk's phone number?

What is Your pay clerk's email address?

Signature of pay clerk / paymaster: Date: / /

If self employed

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury

(net of business expenses, but before income tax and personal deductions e.g. Tax Return)

Who is your accountant?

Accountant's Name:

Accountant's Address:

State: Postcode:

Phone number:

9. The State's declaration

Must be completed by the Affiliated State Management.

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

I _____ *State Manager*

of _____ *Affiliated State*

Confirm that _____ *Member's name*

Sustained the injuries resulting in this claim on:

/ / Date at: : am / pm Time

While playing or training for _____ *Team*

against _____ *Opposition Team*

or while taking part in _____ *Activity*

against _____ *Opposition Team*

at _____ *Place of game or activity*

Signature: _____

Date: _____

State mailing address: _____

State: Postcode: _____

10. Injury data collection

Gallagher is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. Gallagher, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was Your role at the time of Your injury?

☐ Participant ☐ Coach ☐ Umpire/Referee ☐ Other Official
☐ Voluntary Worker ☐ Spectator ☐ Other

If 'Other' please provide details:

What is your estimated absence from playing due to your injury?

☐ No Absence ☐ Less than 1 Week ☐ 1 – 3 Weeks ☐ More than 3 Weeks

How far into the activity were You at the time of the injury?
(Note: Your answer relates to the time into the activity, rather than the period/stage of the game)

☐ Warm up ☐ 1st Bout ☐ 2nd Bout ☐ 3rd Set ☐ 4th Set ☐ 5th Set
☐ Cool Down ☐ Training

On what surface were You participating?

☐ Grass ☐ Synthetic ☐ Concrete / Bitumen ☐ Road
☐ Gravel ☐ Wooden Floor ☐ Piste ☐ Other

If 'Other' please provide details:

What was the condition of the surface?

☐ Dirty / Dusty ☐ Normal ☐ Hard ☐ Wet ☐ Muddy ☐ Other

If 'Other' please provide details:

What were the weather conditions as the time of injury?

☐ Fine ☐ Light Rain ☐ Heavy Rain ☐ Indoor Mist ☐ Other

If 'Other' please provide details:

What were the temperature conditions at the time of injury?

☐ Very Hot ☐ Hot ☐ Hot & Humid ☐ Mild ☐ Cold ☐ Very Cold ☐ Other

If 'Other' please provide details:

How was the onset of injury?

☐ Sudden ☐ Gradual ☐ Started Play With Pre-Existing Injury

If a collision injury, what did You collide with?

☐ Ground ☐ Barrier / Signage ☐ Equipment ☐ Player ☐ Other Structure

If 'Other' please provide details:

What was Your Activity leading to the injury? (please tick more than one if applicable)

☐ Landing ☐ Jumping ☐ Twist / Turn ☐ Attacking ☐ Starting ☐ Stopping
☐ Side Stepping ☐ Running ☐ Blocking ☐ Other

If 'Other' please provide details:

Was protective equipment, tape or support being worn at time of injury?

☐ Yes ☐ No

If yes, please provide details:

☐ Taping ☐ Protective Equipment ☐ Other Support

If 'Protective equipment', please provide details:

If 'Other support', please provide details:

How did the injury severity affect Your participating?

☐ Unable to continue participating ☐ Continued to participate after treatment ☐ Continued to participate without treatment

What was the immediate treatment? (more than one box may be ticked)

☐ Rest ☐ Ice ☐ Compression ☐ Elevation ☐ Stretching ☐ Mobilisation
☐ Taping ☐ Bandaging ☐ Sling ☐ Splint ☐ Other ☐ Unknown

If 'Other' please provide details:

Was a sports trainer / first aid officer present at the activity?

☐ Yes ☐ No ☐ Unknown

If Your injury required referral, to whom were You referred?

☐ Hospital ☐ Doctor ☐ Physiotherapist ☐ Dentist ☐ Other

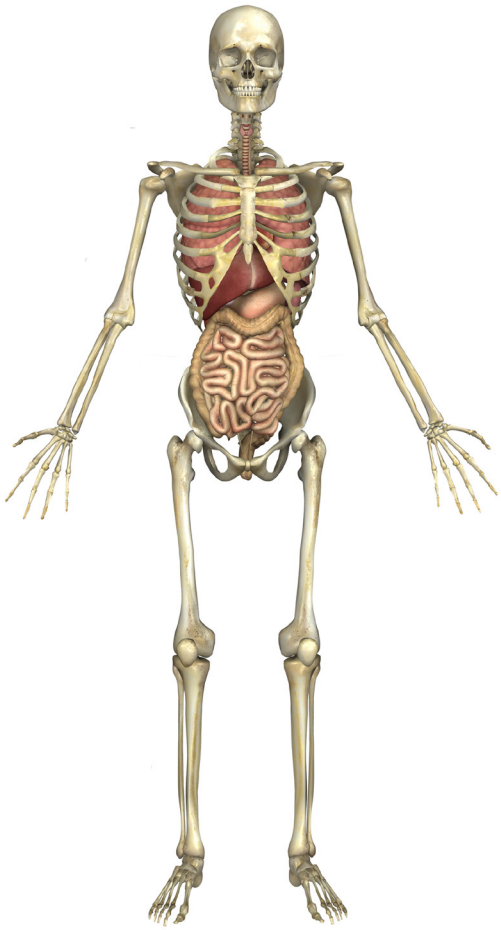
If 'Other' please provide details:

If immediate off site treatment was necessary, what mode of transport was used?

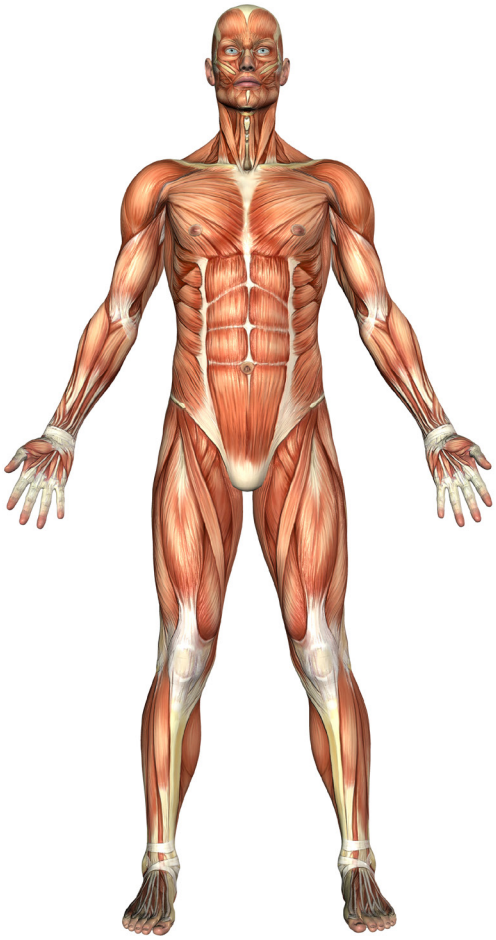
☐ Ambulance ☐ Private Vehicle ☐ Other

If 'Other' please provide details:

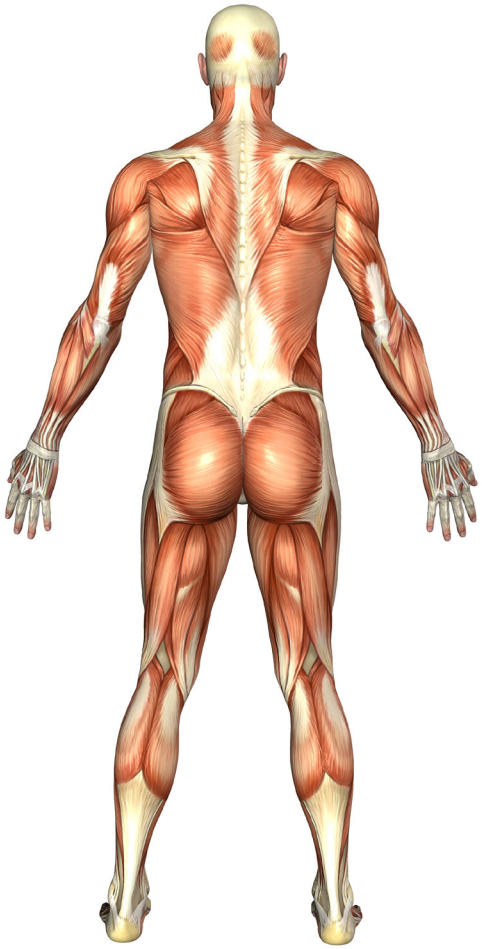
Please indicate the site of your injury on the appropriate diagram below:



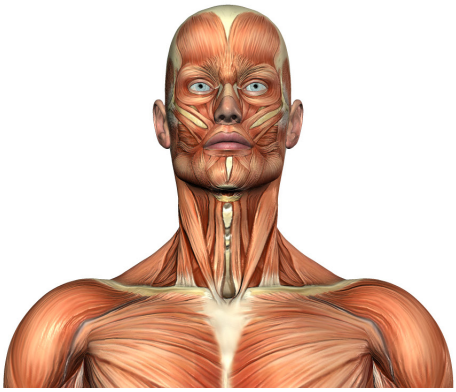
Internal



Front of body



Rear of body



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Disclosure Statement and Privacy Consent

Gallagher and the underwriter as specified on the policy schedule is committed to protecting the privacy of the personal information you provide to us.

We will use the personal information requested on this form to enable us to consider your claim. We may also need to collect additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if your claim is investigated by us.

If you do not provide us with this information, we may not be able to process your claim. We may disclose your personal information we collect on this form and any other additional information we collect in relation to this claim:

- to our relevant staff and contractors involved in delivering our services;
- if a broker collects the claim form from you, to that broker (this is applicable to the claim from only);
- to your employer;
- to your sports association to confirm your eligibility to claim under a policy arranged by it;
- to the insurer and the underwriter as specified on the policy schedule;
- to reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- to facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- to consultant doctors and physicians (in connection with the handling of your claim);
- to claims investigators and surveillance officers (in circumstances where the claim is investigated by us);
- if required to do so by a law enforcement body or by law; and

You may request access to your personal information we hold about you and where necessary, correct any errors in this information (some restrictions and costs may apply).

By completing and returning this form and agreeing to us collecting additional information from the parties specified above in connection with your claim, you agree to us using and disclosing your information as set out above.

This consent to the use and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice.

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold about you is accurate, complete and up-to-date.

I agree that a photostat copy of this document shall be considered as effective and valid as the original and specifically authorised its use as such.

Name (please print): _____

Signed: _____

Date: / /

Must be completed by the injured Member/Athlete or their guardian if the Member/Athlete is under 18 years

Electronic Banking Details (to be completed by the injured person)

Please Provide Account Details to ensure prompt payment of your benefits.

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Bank Name:

Branch Address:

Account in the Name of:

Type of Account:

BSB Number: ☐☐☐ – ☐☐☐

Account Number:

Conditions of this agreement:

- I/We hereby authorise all future payments to be made via electronic funds transfer to the above bank account.
- I/We will be responsible for notifying Gallagher and/or the insurer in writing of any changes in the above particulars. Until receipt of such notifications, Gallagher and/or the insurer shall process all payments in accordance with the above particulars.
- I/We warrant that the bank account details so provided are not false and comply with all applicable laws.
- Gallagher and/or the insurer has the right to accept the authority of the undersigned as conclusive evidence of that persons authority to execute this agreement on behalf of the supplier. Gallagher and/or the insurer is under no obligation to verify the authority of the undersigned on the Bank Account details.
- I/We acknowledge that it is not practicable for Gallagher and/or the insurer to keep banking details confidential, to the extent that these will be available to Gallagher and/or the insurer in carrying out their normal duties in paying accounts.
- Gallagher and/or the insurer will not be responsible for any delays in the payment of errors due to factors outside the reasonable control of Gallagher and/or the insurer (including but not limited to delays and errors in the banking system).
- Gallagher and/or the insurer reserves the right at any time to terminate or suspend this direct credit payment method and to pay by cheque or any other manner which Gallagher and/or the insurer may determine.

Name (please print):

Signed:

Date: / /

PERSONAL INFORMATION PROTECTION STATEMENT

Personal information we collect from you on this Electronic Funds Transfer Form will be used by Gallagher staff for the purpose of making payments to you in respect of your claim. Your personal information will be used for the primary purpose for which it is collected, and will not be disclosed to third parties. Your personal information will be managed in accordance with the National Privacy and Data Protection Act 2014.

Athlete injury medical statement

This form must be completed by the registered medical doctor treating the injury

Medical Statement

Please note: Any charge issued for completion of this form will not be reimbursed, by the insurer.

The Member

Name:

Address:

State: Postcode:

Date of Birth: / /

Sex:

☐ Male ☐ Female

The injury

Complete Diagnosis

History

When did the present disability or injury occur? / /

Date the player ceased work: / /

Is there a history of the same or similar condition?

Is this a recurrence?

☐ Yes ☐ No

Present condition

Subjective symptoms:

Objective finding *(give reports of any x-rays, ECGs or other tests)*

Is the player:

☐ Walking ☐ Bed confined ☐ House confined ☐ Hospital confined

Date of admission: / /

Treatment of present condition

Date of first consultation: / /

Date of latest consultation: / /

Frequency of consultations:

Date of last hospitalisation: / /

Name of hospital:

Nature of surgical procedure:

☐ Contemplated ☐ Performed

Progress

If performed *(date)*: / /

Has condition improved?

☐ Yes ☐ No

If 'No', please explain:

Degree of disability

Has the patient been able to do any work?

☐ Yes ☐ No

If 'No', from what date

Regular work: / / Light duties: / /

When will the patient be able to resume

Regular work: / / Light duties: / /

Other treatment

If the patient was seen in consultation by another doctor, please give the date, name and address of that doctor:

Date: / /

Name:

Address:

State: Postcode:

If the patient is no longer under your care, what date were your services terminated? / /

Other conditions

Describe any other disease or infirmity affecting the patient's present condition:

Please complete the appropriate section if the disability or injury is due to:

Cardiac-circulatory

Blood pressure:

Circulatory disorder – please describe:

Visual

Is the patient totally or industrially blind?

☐ Yes ☐ No

If 'No', what was the vision at last observation:

With Glasses ☐ Distant ☐ Near Date: / /

Without Glasses ☐ Distant ☐ Near Date: / /

What is the extent of any gross visual field defect?

Could vision be improved by treatment, surgery or lenses?

☐ Yes ☐ No

What are the rehabilitation prospects?

Orthopedic

Please report findings of specialist if referred?

Neurological

Please report findings of specialist if referred?

Prognosis

Remarks

Signature: Date: / /

Degree:

Name of Doctor *(please print)*:

Address:

Postcode:

Please apply doctors name stamp below

Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
3. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
4. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

Loss of income claim (if eligible)

5. If you are self-employed have your accountant complete 'Your Employment Details' and supply us with a copy of your last tax assessment.
6. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
7. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete**
2. **Please forward your completed Sports Injury Claim Form to our office within 30 days of your injury. Do no wait for all your medical accounts. Forward them to us as you receive them.**
3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for Gallagher. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 21 working days.

If an issue has not been resolved to your satisfaction, you can lodge a complaint with the Australian Financial Complaints Authority, or AFCA. AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Website: www.afca.org.au

Email: info@afca.org.au

Telephone: 1800 931 678 (free call)

In writing to: Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the Gallagher web site at www.ajg.com.au or telephone 1800 240 432.

Claims handling

Claims are processed at Gallagher Sporting Claims. To maximize claims handling efficiency send your completed claim form and documentation direct to that address.

Email: sport@ajg.com.au

Post:
Gallagher Sporting claims
GPO Box 859, Brisbane, QLD 4001