

**GROUP PERSONAL ACCIDENT CLAIMS PROCEDURES**

**In order for your claim to be processed correctly, please ensure the following forms and documents are provided at the time of lodging your claim to ANDRA. If paperwork including the actual claim form is not completed sufficiently, this may result in a delay with your claim lodgement.**

- Fully completed **Arch Sports Injury** claim form is required. Each question is required to be answered before the claimant's doctor completes the Physicians Statement.
- Enclose all requested information/documentation where relevant.
- Provide a Medical Certificate to substantiate that the injury is covered under the policy. A Medical Certificate simply advising "Medical Treatment" or "Medical Condition" **cannot** be accepted. The Medical Certificate **also** needs confirmation of duties that the employee is unable to perform.
  - Advise the injury sustained/medical condition
  - Confirm duties that the employee is unable to perform
  - Dates of incapacity (from the date of injury)
- Should you continue to be unfit for work (beyond date as stated on medical certificate), you will need to forward an updated medical certificate to support any further payments, reiterating above requirements. Otherwise, please advise us should you return to work.
- Weekly Benefit Claims - the claimant needs to be able to substantiate their income and in order for benefits to be considered, the following is required:
  - Tax File Number Declaration form
  - 12 months wages history report from your Employer or PAYG summary, which can be provided with the Employers Statement from the claim form
  - Copies of payslip for period/dates that reflect leave entitlements used
  - Provide copy of your Superannuation statement / Details of other insurance (*This is required to determine if there is any Income protection cover elsewhere*)
  - Any other evidence or supporting information of earnings

Should the claimant be Self-employed

- Individual / Business tax returns for the last financial year including Notice of Assessment and Profit & Loss Statements

- Claims for Non-Medicare Medical Expenses will require copies of all invoices that the claimant intends to submit as part of the claim when submitting the claim form (or forward at earliest convenience after claim form is lodged).

## SPORTS INJURY CLAIM FORM

### IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.

### SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Policy Number	<input type="text"/>		
Title	Given Name(s)	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M	<input type="checkbox"/> F
Family Name	Date of Birth		
<input type="text"/>	<input type="text"/>		
Residential Address	Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Daytime Contact Number	Alternative Number	Email Address (important)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

### SECTION 2: EFT AUTHORISATION

I hereby authorise and request that Corporate Services Network credit my bank account as indicated below:

Account Holders Name			
<input type="text"/>			
BSB Number	(6-Digits)	Account Number	Bank
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### SECTION 3: DETAILS OF INJURY (1 of 2)

Date of Accident	Time	AM / PM	Address where accident occurred:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Were there any witnesses to the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Witness Name:
			<input type="text"/>
Witness Address:			
<input type="text"/>			
Please describe how the accident / injury occurred:			
<input type="text"/>			

SECTION 3: DETAILS OF INJURY (2 of 2)

What were the injuries?

[Empty text box for injury details]

Have you previously been treated from a similar or same injury?

Yes  No

If Yes, please give details:

[Empty text box for injury treatment details]

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient)

[Empty text box for insurance claim details]

During the 24 hours before the injury, did you drink any alcohol or take any drugs?  Yes  No

If Yes, please state types & quantities:

[Empty text box for alcohol/drug details]

SECTION 5: TREATMENT RECEIVED

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

[Empty text box for treatment received details]

When did you first obtain treatment?

Time

AM / PM

[Empty text box for date]

[Empty text box for time]

[Empty text box for AM/PM]

Name of Current Treating Doctor

Clinic Name/ Address

[Empty text box for doctor name]

[Empty text box for clinic name/address]

Name of Regular Doctor

Clinic Name/ Address

[Empty text box for doctor name]

[Empty text box for clinic name/address]

First consulted Doctor:

[Empty text box for first doctor]

Last consulted Doctor:

[Empty text box for last doctor]

How long have you known this Doctor?

YEARS

MONTHS

Was hospital treatment required?

Yes  No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

**IMPORTANT: PLEASE DO NOT ATTACH ACCOUNTS PAID OR PART PAID BY MEDICARE**

The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount)

Are you a member of an Ambulance Service?  Yes  No If Yes, please give details:

Are you a member of an Private Health Fund?  Yes  No If Yes, please give details:

Does your Private Health Insurance have hospital cover? Yes  No

Does your Private Health Insurance cover extras (Physio etc.)? Yes  No

Name of Provider	Nature of Service (E.g Physio; Dental etc)	Date of Service	Charged Amount (AUD)	Private Health Fund Rebate (If Applicable)	Amount Claimable (AUD)
Total (AUD)					
Less Excess (AUD)					
<b>TOTAL AMOUNT OF CLAIM (AUD)</b>					

SECTION 6 - CLUB / ASSOCIATION DECLARATION

Association / Club Name

Association / Club Official's Name

Association / Club Official's Position

Address

Suburb

State

Postcode

Daytime Contact Number

Email Address (important)

I, the above mentioned Association / Club Official, confirm that (MEMBERS NAME) \_\_\_\_\_ was a registered and Financial member of this association / club and was an insured person as identified in the Personal Accident Insurance 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.

Is there any comments in relation to this claim?

Yes  No

If Yes, please give details

Signature of Official:

Date:

## Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at [www.csnet.com.au](http://www.csnet.com.au) and send to [privacy@csnet.com.au](mailto:privacy@csnet.com.au)

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

## Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN's Privacy Policy and this document.

In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant:

Date:

Name of Claimant:

Signature of Witness (any adult person):

Date:

Name of Witness:

**WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME**Employers Name: This is to Certify that:  has been unable to attend his/her occupation as a result of Injury or SicknessFrom:  Until: His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was: AUD \$: Has your Employees last 12 months payroll history been attached with this report, and if not please provide  Yes  NoHis / Her sick leave entitlement as at the date of injury or illness. Days: He/She has been employed since Date: Please confirm if he/she are still an Employee  Yes  NoPlease confirm date they were no longer employed Date: Has a claim for Worker's Compensation been lodged  Yes  NoIn the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP?  Yes  No**SIGNATURE OF SUPERVISOR or MANAGER:** **NAME OF SUPERVISOR or MANAGER:**   
**(PLEASE PRINT)****TELEPHONE NUMBER:** **DATED:** **DISPUTES**

Corporate Services Network has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer's Internal Dispute Resolution Committee who can review Your complaint.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Australian Financial Complaints Authority under the terms of the General Insurance Code of Practice.

MEDICAL PRACTITIONER'S STATEMENT

The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients Name

DOB:

Height:

Weight:

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause:

Is this condition

an injury  an illness

Does the patient have any other injury or illness that is contributing to the condition?

Yes  No

Provide Details

Date of onset/first symptoms?

When did the patient first consult you for this condition?

Has the patient ever had the same or similar condition?

Yes  No

From when & diagnosis:

Name of patient's usual doctor/medical practice :

How long have you been the patient's usual doctor/medical practice?

If the patient been hospitalized please provide;

Admission Date

Discharge Date

Name of Hospital

Please outline all treatment received to date AND required in the management of your patient's condition.

Please include any relevant medical documents, reports or investigative scans.

Is the patient disabled?

No

- when did the patient return to work?

Yes

- how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

from

to

- partially disabled (able to perform part of their occupation)

from

to

Signature of medical practitioner:

Date:

Name + Qualifications (print):

Address:

Telephone: