

# PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 1<sup>ST</sup> JANUARY 2009 AND 1<sup>ST</sup> JANUARY 2010

**NON-MEDICARE MEDICAL AND LOSS OF INCOME CLAIMS ONLY**

For Policy Wordings, Summary of Cover and other information relating to Personal Injury claims, please refer to:

[www.jltsport.com.au/ffv](http://www.jltsport.com.au/ffv)

**Claims Enquiries:**  
**1300 134 956**

Please send your completed claim form and attachments to:	
SPORTSCOVER AUSTRALIA Locked Bag 6003, Wheelers Hill, Vic, 3150	OR Fax: (03) 8562 9111

**General Enquiries:**  
**1300 130 373**

## HOW TO LODGE A PERSONAL INJURY CLAIM:

- Step 1:** Notify SPORTSCOVER (within 30 days from the date of your injury) of your intention to lodge a claim. You can notify Sportscover via one of the following options:
- Phone: 1300 134 956
  - Email: [claims@sportscover.com](mailto:claims@sportscover.com)
  - Online: [www.sportscover.com](http://www.sportscover.com)
- Step 2:** Access a *current* claim form via [www.jltsport.com.au/ffv](http://www.jltsport.com.au/ffv) or call SPORTSCOVER on 1300 134 956
- Step 3:** Complete *all* sections of the claim form.
- Your claim form may be returned if there is important information missing
  - For assistance contact SPORTSCOVER on 1300 134 956
- Step 4:** Send your claim form (completed in full) to SPORTSCOVER within 120 days from the date of injury.
- Do not wait for all treatments to be completed before sending your claim form.
  - Treatments may continue even after you have submitted your claim form.
- Step 5:** SPORTSCOVER will confirm receipt of your claim form or contact you should they require more information.
- Please contact SPORTSCOVER directly if you have not received confirmation of your claim.

## IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS:

Please read the following information carefully

### Who is SPORTSCOVER?

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

### We legally can not reimburse you for Medicare-related costs:

The Health Insurance Act (Cth) 1973 does not permit the Insurer to reimburse any costs for medical treatments that are registered with Medicare (this includes the Medicare Gap).

### Only Non-Medicare Medical Treatments can be reimbursed (as per the Policy Wording):

- All treatments must be certified as "necessary" by your physician. i.e. Doctor, physiotherapist, etc
- Please refer to JLT Sport's web site for benefits, excesses and special conditions/exclusions [www.jltsport.com.au/ffv](http://www.jltsport.com.au/ffv)

### Attach Original Receipts:

- Send original receipts with your claim form (unless retained by your private health fund).

### If you have Private Health Cover:

- Claim on your private health fund first and attach a copy of their rebate advice to this form.

### Examples of items covered by Medicare.

**We can not reimburse you for these costs.**

- Doctor
- Surgeon
- Surgeon's Assistant
- Anaesthetist
- X-rays
- MRI Scans\*
- Public Hospitals

### Examples of Non-Medicare items.

**Claimable as per the Policy Schedule.**

- Ambulance
- Physiotherapist
- Dental
- Private Hospital Accommodation
- Chiropractor
- MRI Scans\*

PLEASE NOTE:

\* MRI scans are generally claimable through Medicare, however please check with your referrer and/or provider to confirm if this is the case prior to lodging your claim.

## CLAIM FORM CHECKLIST: Please use the checklist below to ensure ALL sections are completed as required.

SECTION A:	SECTION B:	SECTION C:*	SECTION D:
<input type="checkbox"/> Claimant's details <input type="checkbox"/> Injury details <input type="checkbox"/> Signed by Claimant	<input type="checkbox"/> Club declaration <input type="checkbox"/> Signed by authorised club representative	<input type="checkbox"/> Confirmation of Loss of Income Cover <input type="checkbox"/> Employment Details <input type="checkbox"/> Signed by Employer	<input type="checkbox"/> Injury details <input type="checkbox"/> Signed by your physician

\* Section C must be completed only when claiming for Loss of Income. Loss of Income is an OPTIONAL cover. Before lodging your claim, please obtain verification from your club or league that you are covered for Loss of Income Benefits for 2008.



JLT SPORT

2009 FFV RISK PROTECTION PROGRAMME

SECTION A: CLAIM DETAILS



FOOTBALL FEDERATION VICTORIA



THIS SECTION MUST BE COMPLETED IN FULL BY THE CLAIMANT OR A LEGAL GUARDIAN IF THE CLAIMANT IS UNDER 18 YEARS OF AGE.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST JANUARY 2010

PLEASE SEND YOUR COMPLETED CLAIM FORM AND ORIGINAL RECEIPTS TO:

SPORTSCOVER AUSTRALIA, LOCKED BAG 6003, WHEELERS HILL, VIC, 3150 | OR FAX: (03) 8562 9111

PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 Male / Female 4 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Claimant's Surname Claimant's First Name Gender Date of Birth (DD/MM/YYYY)

5 \_\_\_\_\_ 6 ( )  
 Claimant's Personal Mailing Address State Post Code Contact Phone Number

7 \_\_\_\_\_ 8 ( ) 9 \_\_\_\_/\_\_\_\_/\_\_\_\_ 10 \_\_\_\_:\_\_\_\_am/pm  
 Claimant's Occupation (if applicable) Work Phone Number Date of Injury (DD/MM/YYYY) Approx. Time of Injury (HH:MM)

11 \_\_\_\_\_ 12 \_\_\_\_\_  
 Club Name League/Association Name

13 Describe the injury and how it happened (please use additional pages if required).

14 Describe any other factors that may have contributed to your injury (leave blank if not applicable).

15 Where did the injury occur?  Indoor  Outdoor

16 What was the surface type at the time of injury?  Grass  Indoor surface  Concrete/asphalt  Other \_\_\_\_\_  
Please specify

17 What were the weather conditions?  Fine  Rain  Showers  Extreme heat  Extreme cold  Other \_\_\_\_\_  
Please specify

18 What were the surface conditions?  Wet  Dry  Muddy  Hard

19 What were your circumstances at the time of injury?  Playing  Training  Travelling  Other \_\_\_\_\_  
Please specify

20 Which category were you playing?  Seniors  Thirds  Juniors  Women's  Masters

21 In which half were you injured?  1<sup>st</sup>  2<sup>nd</sup>

22 How did the injury occur?  Fall  Slip/Trip  Overuse  Other \_\_\_\_\_  
Please specify

23 Please indicate when you intend to resume the following activities. If exact dates are not known, please provide approximates.  
 \_\_\_\_/\_\_\_\_/\_\_\_\_  N/A      \_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_  
 When will you resume WORK?      When will you resume TRAINING?      When will you resume PLAYING?

24 Do you have private health cover?  YES  NO

25 If yes, what is the name of your private health fund? \_\_\_\_\_

26 Please indicate the covers offered by your private health fund  Dental costs  Physiotherapy costs  
 Ambulance  Hospital costs

27 Are you a member of the Ambulance Service?  Yes  NO

28 Please indicate to whom re-impbursement cheques are to be made payable:  
 Myself  Other

\_\_\_\_\_  
 Contact Person Cheque made payable to

\_\_\_\_\_  
 Address State Post code

**CLAIMANT DECLARATION:**  
 I, the undersigned, hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other authorised members of The Football Federation Risk Protection Programme arranged by JLT Sport. I allow this information to be used as part of the risk management processes and reporting criteria. I authorise any hospital, physician or other person who has attended me or any employer, to furnish JLT Sport or its representatives 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 all records of employers. I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the forgoing particulars are true and correct in every detail. I agree that if I have made, or shall make in any further declaration in respect to said injury, any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the covers shall be void and all rights to recover there under in respect to past or future injuries shall be forfeited.

29 \_\_\_\_\_  
 Claimant's signature (or Parent/Guardian if under 18 years) \_\_\_\_\_  
 Date



JLT SPORT

2009 FFV RISK PROTECTION PROGRAMME



FOOTBALL FEDERATION VICTORIA



SECTION B: CLUB DECLARATION

THIS SECTION MUST BE COMPLETED IN FULL BY AN AUTHORISED CLUB OR LEAGUE REPRESENTATIVE

FOR INJURIES SUSTAINED BETWEEN 1<sup>ST</sup> JANUARY 2009 AND 1<sup>ST</sup> JANUARY 2010

PLEASE PRINT

I, the undersigned, as authorised representative of \_\_\_\_\_ hereby declare that  
Name of Club

\_\_\_\_\_ sustained the injuries outlined on this claim form on \_\_\_\_\_  
Name of Claimant Date of Injury

at \_\_\_\_\_ whilst  Playing  Training for \_\_\_\_\_  
Time of Injury Select one Name of Claimant's Club/Team  Home team  
 Away team

at \_\_\_\_\_ against \_\_\_\_\_  
Name of Ground/Place of Injury Name of Opposition Club/Team (if applicable)

I confirm that the Claimant  Has not returned to playing/training.  
 Returned to playing/training on: \_\_\_\_\_  
Date Claimant returned

I confirm that \_\_\_\_\_  Has not purchased additional Loss of Income Cover for 2008.  
Name of Claimant's Club  Has purchased additional Loss of Income Cover for 2008 as per details below.

**Loss of Income Cover Details:**  
Please indicate below the additional Loss of Income Cover purchased by the club for 2008. The cover is in addition to the \$200 per week already provided:

Junior Team  Senior/Thirds/Womens/Masters Team \$ \_\_\_\_\_ Per week \_\_\_\_\_  
Date of Purchase

**CLUB/LEAGUE DECLARATION.** This must be signed by an authorised club representative. If blank, your claim may be delayed.

\_\_\_\_\_  
Authorised Club Representative's name (please print) Authorised Club Representative's Title/Position

\_\_\_\_\_  
Authorised Club Representative's signature Date

**LOSS OF INCOME BENEFITS:**

If a player is injured whilst participating in a club activity and unable to work full time as a result of their injury, the Loss of Income Cover provides reimbursement for either 75% of the injured person's net weekly income or \$200 per week – whichever is the lesser. Coverage is for a maximum of 52 weeks and a 14 day elimination period applies.

Clubs can choose to Upgrade Loss of Income Cover to any amount to a maximum of \$1,000 per week. Upgrades are only available in \$100 increments. Clubs must purchase extra cover for an additional premium as per JLT Sport's Upgrade Form (for details please refer to [www.iltssport.com.au/ffv](http://www.iltssport.com.au/ffv)).

If claiming for Loss of Income Benefits you must complete Section A and Section B of this form, and have Section C completed by your employer. Section D must be completed including the Incapacity to Work Statement completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor etc.



JLT SPORT



2009 FFV RISK PROTECTION PROGRAMME



FOOTBALL FEDERATION VICTORIA

SECTION C: LOSS OF INCOME BENEFITS

THIS SECTION MUST BE COMPLETED ONLY IF YOU ARE CLAIMING LOSS OF INCOME BENEFITS.

LOSS OF INCOME IS AN OPTIONAL COVER.

PLEASE CHECK WITH YOUR CLUB PRIOR TO COMPLETING THIS SECTION TO ENSURE YOU ARE COVERED FOR LOSS OF INCOME BENEFITS.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST JANUARY 2010

PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.

1 – 6 to be completed by the Claimant.

- 1 Do you wish to claim for Loss of Income Benefits?
2 Has your club purchased additional Loss of Income Cover?
3 If Yes, what is the total weekly amount you are covered for?
4 Can you claim compensation under Worker's Compensation or any other policy that includes loss of income benefits?
5 Have you ever made any previous claims in respect to a personal accident insurance policy or plan?
6 Have you engaged in any other income earning employment since you became injured?

7 – 20 to be completed by the Employer\*.

7 Name of Employer (Business Name)
8 Name of Contact Person
9 Employer's address
10 Employer's Phone Number
11 Employer's Facsimile Number
12 Date Employee commenced with the organisation
13 Employee's NET weekly salary as at date of injury
14 Employee's GROSS weekly salary as at date of injury
15 What is the Employee's income definition
16 Date Employee ceased work due to injury
17 Date expected to resume normal duties
18 Has the Employee returned to work?
19 During the period of incapacity has the employee received a salary?
20 If Employed - Salary Officer's Name (please print)
If Employed - Salary Officer's signature
If SELF EMPLOYED - Accountant's name (please print)
If SELF EMPLOYED - Accountant's signature

\*Please note: If you are SELF EMPLOYED, please have your Accountant complete this section.





JLT SPORT

2009 FFV RISK PROTECTION PROGRAMME



FOOTBALL FEDERATION VICTORIA



SECTION D: PHYSICIAN'S REPORT (CONTINUED)

15 Have you referred the patient to any other services or treatment?  Yes  NO

16 If YES, please specify the approximate number of treatments required.

Physiotherapy \_\_\_\_\_  
Treatments required

Chiropractics \_\_\_\_\_  
Treatments required

Surgery \_\_\_\_\_  
Treatments required Please provide surgery details

Other \_\_\_\_\_  
Treatments required Please provide details

17 Has the patient been able to do any work since the injury occurred?  Yes  NO

18 What date do you advise the patient to return to playing football? \_\_\_\_\_  
Date advised to return to football

I, the undersigned, declare that I have examined the Claimant's injury as described on this form. I hereby declare that all information I have provided on this form is true and accurate as at the date of examination.

19 \_\_\_\_\_  
Physician's name (please print) Physician's Phone Number  
\_\_\_\_\_  
Physician's signature \_\_\_\_\_ Date

**Incapacity to Work Statement** *Only complete this section if claiming for Loss of Income.*  
Incapacity to Work Statement must be completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist).  
It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

I, \_\_\_\_\_ examined \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Medical Practitioner's name Claimant's name Date of Examination

In my opinion, this person is/has been unfit for work from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ inclusive.  
First date of incapacity to work Last date of incapacity to work

Please provide any further comments/remarks in regard to your assessment of this injury/condition.

\_\_\_\_\_  
Medical Practitioner's Name Medical Practitioner's Phone Number  
\_\_\_\_\_  
Medical Practitioner's Address State Post Code  
\_\_\_\_\_  
Medical Practitioner's Signature \_\_\_\_\_ Date