

# PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 31<sup>ST</sup> DECEMBER 2008 AND 31<sup>ST</sup> DECEMBER 2009

**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.jlt sport.com.au/gymnastics](http://www.jlt sport.com.au/gymnastics)**

**Claims Enquiries:**  
**1300 363 413**

Please send your completed claim form and attachments to:

SUA Claims Department  
PO Box 2717,  
Taren Point, NSW, 2229

OR

Fax:  
02 9524 9003

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

## HOW TO LODGE A PERSONAL INJURY CLAIM:

- Step 1:**
- Within 28 days from the Date of Injury, please notify SUA Claims Department on 1300 363 413 of your intent to lodge a claim.
- Step 2:** Download Gymnastics Australia's claim form via [www.jlt sport.com.au/gymnastics](http://www.jlt sport.com.au/gymnastics) or call SUA 1300 363 413
- Step 3:** Complete *all* sections of the claim form.
- Your claim form may be returned if there is important information missing
  - For assistance, please contact SUA Claims Department 1300 363 413
- Step 4:** Send your claim form (completed in full) to SUA Claims Department – PO Box 2717, Taren Point NSW 2229
- 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:** SUA will confirm receipt of your claim form or contact you should they require more information.
- Please contact SUA directly if you do not receive confirmation of your claim.

## IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS:

Please read the following information carefully

### SUA can not legally reimburse you for Medicare-related costs or the Medicare Gap:

The Health Insurance Act (Cth) 1973 does not permit the Insurer to reimburse any costs that are registered with Medicare (this includes the Medicare Gap). For information regarding Medicare please refer to [www.medicare.gov.au](http://www.medicare.gov.au)

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

- All treatments must be certified as "necessary" by your physician. i.e. Doctor, physiotherapist, etc
- Please refer to JLT Sport's web site for policy wording, terms, conditions and exclusions [www.jlt sport.com.au/gymnastics](http://www.jlt sport.com.au/gymnastics)

### If you have Private Health Cover:

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

### Attach Original Receipts:

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

## LOSS OF INCOME CLAIMS:

Loss of Income Cover provides reimbursement for either 75% of the injured person's net weekly income or \$300 – whichever is the lesser. The injured person must be in permanent employment at the time of injury and lose 14 days income as a result of the injury sustained before the claim is payable. For further details regarding Loss of Income Benefits, please refer to [www.jlt sport.com.au/gymnastics](http://www.jlt sport.com.au/gymnastics) or contact JLT Sport on 1300 130 373.

### Examples of items covered by Medicare.

**You can not claim for these items.**

- 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:

\* Some MRI machines are not registered with Medicare. Please check with your treating physician before 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 and research data <input type="checkbox"/> Signed by Claimant	<input type="checkbox"/> Club/Association Declaration <input type="checkbox"/> Signed by authorised representative	<input type="checkbox"/> Employment Details <input type="checkbox"/> Signed by Employer	<input type="checkbox"/> Physician's Report <input type="checkbox"/> Injury details <input type="checkbox"/> Signed by your physician

## SECTION A: CLAIM DETAILS

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 31<sup>ST</sup> DECEMBER 2008 AND 31<sup>ST</sup> DECEMBER 2009**

PLEASE SEND YOUR COMPLETED CLAIM FORM AND ORIGINAL RECEIPTS TO: SUA CLAIMS DEPARTMENT, PO BOX 2717, TAREN POINT NSW 2229  
PLEASE PRINT CLEARLY BELOW - If there is insufficient space, please attach additional pages.

### CLAIMANT INFORMATION

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

5 \_\_\_\_\_ 6 \_\_\_\_\_  
 Claimant's Personal Mailing Address State Post Code Claimant's Email Address

7 \_\_\_\_\_  
 Claimant's After Hours Number Mobile Number Fax Number

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 \_\_\_\_\_ 13 \_\_\_\_\_  
 State Gymnastics Association's Name Club's Name Claimant's Membership Number

14 \_\_\_\_\_  
 Venue Name and address of where the injury occurred

15 **Have you attached to this claim a copy of the Injury Report Form completed by the club at the time of the injury?**  Yes  No

16 \_\_\_\_\_  
 Please describe the injury and how it happened (please use additional pages if required).

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

18 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  N/A \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  N/A  
 When will you resume WORK? When will you resume TRAINING/PARTICIPATION? When will you resume COMPETING?

19 **Do you have private health cover?**  Yes  No (if No, please proceed to question 21)  
 If yes, what is the name of your private health fund? \_\_\_\_\_

20 **Please indicate the covers offered by your private health fund**  
 Dental Costs  Ambulance  Physiotherapy costs  Private Hospital  
 Chiropractor  Massage  Other ancillary procedures \_\_\_\_\_  
Please specify

21 **Are you a member of the Ambulance Service?**  Yes  No

22 **Have you ever lodged a personal accident claim before?**  Yes  No  
 If yes, please provide basic details. \_\_\_\_\_

23 **Are you making, or entitled to make, a claim in respect of this injury for any of the following?**  
 Sick Leave  Workers Compensation  Motor Government Benefits  Superannuation Life Insurance  
 If yes, please provide details. \_\_\_\_\_

24 **Are you now, or have you ever been, subject to or affected by other injury(ies) or Disease, Deformity, or Defect of Senses?**  Yes  No  
 If yes, please provide details. \_\_\_\_\_

25 **To whom would you like re-imburement made payable?**  Myself  Other: \_\_\_\_\_  
Please specify

**NOTE:** Once your claim has been settled, we can, if you wish, transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no cheque clearance delays.

26 **How would you like re-imburement to be made?**  Cheque  Bank transfer  
 If bank transfer, please provide details.  
 Bank Name \_\_\_\_\_  
 Beneficiary Name \_\_\_\_\_  
 BSB Number 

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 Account Number 

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## SECTION A: CLAIM DETAILS (CONTINUED)

### INJURY RESEARCH DATA – THIS INFORMATION MUST BE COMPLETED

- 27 **When the injury occurred, in which Gymsport were you involved?**  
 Men's Artistic       Women's Artistic       Rhythmic       General Gymnastics  
 Kindergym       Sport Aerobics       Trampoline Sports       Sports Acrobatics
- 28 **Type of involvement?**  
 Recreational       State Levels       National Levels       Elite/International       Other \_\_\_\_\_  
Please specify
- 29 **Injured person?**  
 Athlete/Participant       Coach       Judge       Official       Other \_\_\_\_\_  
Please specify
- 30 **How did the injury occur?**  
 Fall       Slip/Trip       Collision       Overuse       Overbalance       Other \_\_\_\_\_  
Please specify
- 31 **When did the injury occur?**  
 Warm Up       Warm Down       Training/Lesson       Competition/Event       Other \_\_\_\_\_  
Please specify
- 32 **Did the injury involve any apparatus or equipment?**  
 On apparatus/equipment       With hand apparatus       No apparatus/equipment involved       Other \_\_\_\_\_  
Please specify
- 33 **What were you attempting to do at the time of the injury?**  
 New skill or activity       Pre-learnt skill or activity       General activity       Other \_\_\_\_\_  
Please specify

### CLAIMANT DECLARATION

**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 Gymnastics Australia's National 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.

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

## SECTION B: CLUB DECLARATION

**THIS SECTION MUST BE COMPLETED IN FULL BY AN AUTHORISED CLUB OR STATE ASSOCIATION REPRESENTATIVE**  
 PLEASE PRINT DETAILS BELOW - If there is insufficient space to answer a question, please attach additional pages.

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

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

at \_\_\_\_\_ whilst  Competing  Training/participating for \_\_\_\_\_  
Time of Injury Select one Name of Claimant's Club

at \_\_\_\_\_ during \_\_\_\_\_  
Name of Venue/Place of Injury Name of Event (if injury occurred during competition/event)

I confirm that \_\_\_\_\_ is a current affiliate of the State Association and/or Gymnastics Australia.  
Name of Claimant's Club

I acknowledge that personal injury claims may only be made by members of the State Gymnastics Association and/or Gymnastics Australia.

I confirm that the Claimant is currently registered with the State Gymnastics Association and/or Gymnastics Australia.

The Claimant's Membership ID Number is: \_\_\_\_\_ (Please contact your State Association for membership details)  
Membership ID Number (if applicable)

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

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

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

\_\_\_\_\_  
Authorised Club Representative's Position/Title

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

\_\_\_\_\_  
Date

## SECTION C: LOSS OF INCOME BENEFITS

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

**FOR INJURIES SUSTAINED BETWEEN 31<sup>ST</sup> DECEMBER 2008 AND 31<sup>ST</sup> DECEMBER 2009**

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

**1 – 4 to be completed by the Claimant.**

- 1 Do you wish to claim for Loss of Income Benefits?  YES  NO *If NO, please proceed to Section D*
- 2 Can you claim compensation under Worker's Compensation or any other policy that includes loss of income benefits?  YES  NO
- 3 Have you made any previous claims in respect to a personal accident insurance policy or plan?  YES  NO
- 4 Have you engaged in any other income earning employment since you became injured?  YES  NO

**5 – 17 to be completed by the Employer\*.**

- 5 \_\_\_\_\_ 6 \_\_\_\_\_  
Name of Employer (Business Name) Name of Contact Person
- 7 \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_  
Employer's address
- 8 ( ) \_\_\_\_\_ 11 ( ) \_\_\_\_\_ 9 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Employer's Phone Number Employer's Facsimile Number Date Employee commenced with the organisation
- 10 \$ \_\_\_\_\_ 11 \$ \_\_\_\_\_  
Employee's NET weekly salary as at date of injury Employee's GROSS weekly salary as at date of injury  
*If self employed, please provide average weekly salary based on 12 month period directly prior to injury.*
- 12 What is the Employee's income definition  Full Time  Part Time  Casual  Self Employed
- 13 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 14 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Employee ceased work due to injury Date expected to resume normal duties
- 15 Has the Employee returned to work?  YES  NO If YES, what date? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- 16 During the period of incapacity has the employee received a salary?  YES  NO If YES, What for?  Sick leave  
 Annual leave  
 Other
- Salary received from \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- Net of business expenses, personal deductions and income tax. Payment excludes bonuses, commissions, and other allowances.*

- 17 \_\_\_\_\_  
If Employed - Salary Officer's Name (please print) Salary Officer's Phone Number \_\_\_\_\_
- \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
If Employed - Salary Officer's signature Date
- \_\_\_\_\_ \_\_\_\_\_  
If SELF EMPLOYED - Accountant's name (please print) Accountant's Phone Number \_\_\_\_\_
- \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
If SELF EMPLOYED - Accountant's signature Date

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

If claiming Loss of Income Benefits, please ensure the Incapacity to Work Statement in Section D is completed by a Medical Practitioner.

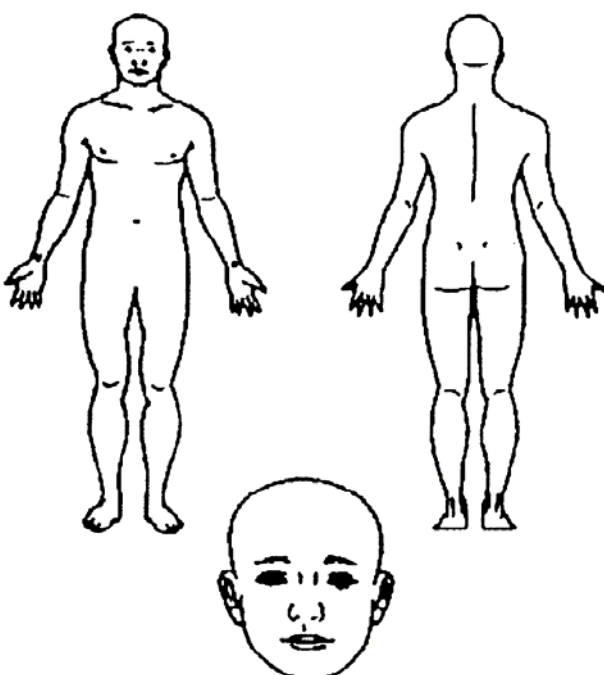
Missing information may cause delays in the settlement of your claim.

## SECTION D: PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED IN FULL BY YOUR TREATING PHYSICIAN.

**FOR INJURIES SUSTAINED BETWEEN 31<sup>ST</sup> DECEMBER 2008 AND 31<sup>ST</sup> DECEMBER 2009**

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

<p>1 _____</p> <p>Claimant's Surname</p>	<p>2 _____</p> <p>Claimant's First Name</p>
<p>3 _____</p> <p>Claimant's Injury Date</p>	<p>4 _____</p> <p>Treating Physician's Name (Please Print)</p>
<p>5</p> <p>Diagnosis / History of Injury</p>     	
<p>6</p> <p>Injury location</p> <div style="text-align: center;">  </div> <p>Please CIRCLE and NAME the area of the body where the injury is located.</p>	<p>7</p> <p>Injury type</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bruising</li> <li><input type="checkbox"/> Concussion</li> <li><input type="checkbox"/> Cut</li> <li><input type="checkbox"/> Dental</li> <li><input type="checkbox"/> Dislocation</li> <li><input type="checkbox"/> Fracture</li> <li><input type="checkbox"/> Multiple</li> <li><input type="checkbox"/> Rupture (Internal Organs)</li> <li><input type="checkbox"/> Sprain (ligament)</li> <li><input type="checkbox"/> Strain (muscle/tendon)</li> </ul>
<p>8</p> <p>When did the patient first receive medical treatment for the above injury?</p> <p>_____/_____/_____</p> <p>Date of treatment</p> <hr/> <p>Name of attending physician</p> <hr/> <p>Address</p> <hr/> <p>State _____ Post code _____</p>	
<p>9 Do you consider the Patient's injury to be a NEW injury? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> NO</span></p> <p>10 Do you consider the Patient's injury to be a RECURRENCE of a previous injury? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> NO</span></p> <p>11 If you consider this injury to be a recurrence of a previous injury, please provide details and a description.</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>12 Does the Patient have any congenital defects or chronic diseases? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> NO</span></p> <p>13 If YES, please provide details (including dates, name of treating doctor and description).</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Please continue to page 7.

## SECTION D: PHYSICIAN'S REPORT (CONTINUED)

14	Have you referred the patient to any other services or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
15	If YES, please specify the approximate number of treatments required.		
	<input type="checkbox"/> Physiotherapy		Treatments required
	<input type="checkbox"/> Chiropractics		Treatments required
	<input type="checkbox"/> Surgery		
	Treatments required	Please provide surgery details	
	<input type="checkbox"/> Other: _____		
	Please specify	Treatments required	Please provide details
16	Has the patient been able to do any work since the injury occurred?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
17	What date do you advise the patient should return to Gymnastics?		
		Date advised to return to Gymnastics	
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.			
18			
	Physician's name (please print)	Physician's Phone Number	
	Physician's signature	Date	
<b>Incapacity to Work Statement</b>		<i>Only complete this section if claiming for Loss of Income.</i>	
The 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	
	Medical Practitioner's name		Claimant's name
		on	
			Date of Examination
In my opinion, this person is/has been unfit for work from		to	
	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	

PLEASE SEND YOUR COMPLETED CLAIM FORM INCLUDING SECTIONS A, B, C AND D WITH ALL ORIGINAL RECEIPTS TO:

**SUA Claims Department**  
**PO Box 2717,**  
**Taren Point, NSW, 2229**  
**Phone: 1300 363 413**