

PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 31ST DECEMBER 2008 AND 1ST NOVEMBER 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.jltsport.com.au/netballaustralia

Claims Enquiries:
1800 640 009

Please send your completed claim form and attachments to:	
Echelon Claims Services PO Box 7170, Hutt Street, SA 5000	OR Fax: (08) 8235 6450

General Enquiries:
1300 130 373

HOW TO LODGE A PERSONAL INJURY CLAIM:

- Step 1:** Access a *current* claim form via www.jltsport.com.au/netballaustralia or call Echelon on 1800 640 009
- Step 2:** Complete *all* relevant sections of the claim form.
- Your claim form may be returned if there is important information missing
 - For assistance contact Echelon on 1800 640 009
- Step 3:** Send your claim form to Echelon within **180 days** from the date of injury.
- If treatment of the injury is likely to continue beyond 180 days, please send through your claim form within 180 days with any current receipts received and contact Echelon for further assistance.
- Step 4:** Echelon will confirm receipt of your claim form or contact you should they require more information.
- Please contact Echelon directly if you have not received confirmation of your claim within 2 weeks from the date of lodgement.

IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS: *Please read the following information carefully*

Who is Echelon?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of Jardine Lloyd Thompson Pty Ltd. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the Netball Australia National Risk Protection Program.

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

The Health Insurance Act (Cth) 1973 does not permit the Insurer or the Trustee to reimburse you for any costs of 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/netballaustralia

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.

Privacy of your personal details:

- We collect, store and use your personal details in-line with the Privacy Act (Cth) 1988. For a copy of our Privacy Statement please contact JLT Sport on 1300 130 373 or view it online
www.jltsport.com.au

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.

LOSS OF INCOME CLAIMS:

Loss of Income Cover provides reimbursement for either 80% of the injured person's net weekly income or the dollar amount selected by the Member Organisation (see below) – whichever is the lesser. The injured person must lose 14 days income as a result of the injury sustained before the claim is payable.

- Members of **Netball NT, Netball Queensland, Netball SA, Netball Tasmania and Netball Victoria** are covered for **\$250 per week**.
- Members of **Netball WA** are covered for **\$300 per week**.
- Members of the **Australian Open Squad, Australian Under 21 Squad and ANZ Championship Teams** are covered for **\$1000 per week**.

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"/> Club/Association Declaration	<input type="checkbox"/> Employment Details	<input type="checkbox"/> Physician's Report
<input type="checkbox"/> Injury details and research data	<input type="checkbox"/> Signed by authorised representative	<input type="checkbox"/> Signed by Employer	<input type="checkbox"/> Injury details
<input type="checkbox"/> Signed by Claimant			<input type="checkbox"/> Signed by your physician

CLAIM FORM SECTION A:

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 31ST DECEMBER 2008 AND 1ST NOVEMBER 2009

PLEASE SEND YOUR COMPLETED CLAIM FORM AND ORIGINAL RECEIPTS TO:

ECHOLON CLAIMS SERVICES, PO BOX 7170, HUTT STREET, SA 5000 | OR FAX: (08) 8235 6450

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

1 _____ Claimant's Surname	2 _____ Claimant's First Name	3 <u>Male / Female</u> Gender	4 ____/____/____ Date of Birth (DD/MM/YYYY)
5 _____ Claimant's Personal Mailing Address	_____ State	_____ Post Code	6 () _____ Contact Phone Number
7 _____ Claimant's Occupation (if applicable)	8 () _____ Work Phone Number	9 ____/____/____ Date of Injury (DD/MM/YYYY)	10 _____:_____ am/pm Approx. Time of Injury (HH:MM)
11 _____ Team Name (if appropriate)	12 _____ Club Name	13 _____ Claimant's Membership Number	
14 _____ Association Name	15 _____ Name of Opposing Team / Club (if applicable)	16 _____ Name of Event/Tournament	
17 Describe the injury and how it happened (please use additional pages if required). _____ _____			
18 Describe any other factors that may have contributed to your injury (leave blank if not applicable). _____			
19 Where did the injury occur? <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor Name of Venue: _____			
20 What was the surface type at the time of injury? <input type="checkbox"/> Timber <input type="checkbox"/> Synthetic <input type="checkbox"/> Concrete/asphalt <input type="checkbox"/> Other _____ <small>Please specify</small>			
21 What were the weather conditions? <input type="checkbox"/> Fine <input type="checkbox"/> Rain <input type="checkbox"/> Showers <input type="checkbox"/> Extreme heat <input type="checkbox"/> Extreme cold <input type="checkbox"/> Other _____ <small>Please specify</small>			
22 What were the surface conditions? <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Other _____ <small>Please specify</small>			
23 What were your circumstances at the time of injury? <input type="checkbox"/> Playing <input type="checkbox"/> Training <input type="checkbox"/> Travelling <input type="checkbox"/> Other _____ <small>Please specify</small>			
24 In which period were you injured? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> Other _____ <small>Please specify</small>			
25 How did the injury occur? <input type="checkbox"/> Fall <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Collision <input type="checkbox"/> Other _____ <small>Please specify</small>			
26 Please indicate when you intend to resume the following activities. If exact dates are not known, please provide approximates. _____/_____/_____ When will you resume WORK? <input type="checkbox"/> N/A			
_____/_____/_____ When will you resume TRAINING?			
_____/_____/_____ When will you resume COMPETING?			
27 Do you have private health cover? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please proceed to question 30)			
28 If yes, what is the name of your private health fund? _____			
29 Please indicate the covers offered by your private health fund <input type="checkbox"/> Dental costs <input type="checkbox"/> Physiotherapy costs <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital costs			
30 Are you a member of the Ambulance Service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
31 Please indicate to whom re-imburement cheques are to be made payable: <input type="checkbox"/> Myself <input type="checkbox"/> Other _____ <small>Contact Person</small> _____ <small>Cheque made payable to</small>			
_____ <small>Address</small> _____ <small>State</small> _____ <small>Post code</small>			
I, the undersigned, hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other authorised members of the JLT Sport (Netball Australia National Risk Protection Program) Discretionary Trust Arrangement. I allow this information to be used as part of the Trust's 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 foregoing 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.			
32 _____ Claimant's signature (or Parent/Guardian if under 18 years)			_____/_____/_____ Date

CLAIM FORM SECTION B: CLUB/ASSOCIATION DECLARATION

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

FOR INJURIES SUSTAINED BETWEEN 31ST DECEMBER 2008 AND 1ST NOVEMBER 2009

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 Netball Club/Association

_____ 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

at _____ against _____
Name of Venue/Place of Injury Name of Opposition Club/Team (if injury occurred during a game)

I confirm that _____ is a current affiliate of the State Member Organisation and/or Netball Australia.
Name of Claimant's Club/Team

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

I confirm that the Claimant is currently registered with the State Netball Member Organisation and/or Netball Australia.

The Claimant's Membership ID Number is: _____ (Please contact your State MO 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.*

_____ <small>Authorised Netball Club/Association Representative's name (please print)</small>	_____ <small>Authorised Netball Club/Association Representative's Position/Title</small>
_____ <small>Authorised Netball Club/Association Representative's signature</small>	_____ <small>Date</small>
_____ <small>Authorised Netball Club/Association Representative's contact email</small>	_____ <small>Authorised Netball Club/Association Representative's contact number</small>

Membership Information:

For further details regarding membership and confirmation of current membership status, please contact your State Netball Member Organisation. It is a requirement in most States that all members must be registered on a central database prior to processing a Personal Injury Claim. **JLT Sport does not administer membership registrations.**

Please visit your State Member Organisation's web site for more information and contact details:

- Netball NT www.nt.netball.asn.au
- Netball Queensland www.netballq.org.au
- Netball SA www.netballsa.asn.au
- Netball Tasmania www.tas.netball.asn.au
- Netball Victoria www.netballvic.com.au
- Netball WA www.netballwa.com.au

To assist Echelon process your claim, please ensure your Membership ID Number is included above. If you do not have a Membership ID, your claim may take longer to process. Each Claimant must be verified as a current member of Netball prior to processing a claim.

Official Netball Activities ONLY:

If you were injured whilst participating in a non-sanctioned event, competition, tournament or any other unofficial Netball activity (that was not associated with an affiliated club/association of the State Member Organisation), your claim may be declined. The Personal Accident Policy stipulates that cover is provided only to members participating in "Official" Netball activities (including games, training and functions).

Please refer to www.jlt sport.com.au/netballaustralia for the Policy Wordings, Summary of Cover, Terms and Conditions. If you are unsure whether your game or event was an official Netball activity, please contact your State Netball Member Organisation for confirmation.

CLAIM FORM SECTION C: LOSS OF INCOME BENEFITS

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

FOR INJURIES SUSTAINED BETWEEN 31ST DECEMBER 2008 AND 1ST NOVEMBER 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

4 – 17 to be completed by the Employer*.

<p>5 _____ Name of Employer (Business Name)</p> <p>7 _____ Employer's address</p> <p>8 () _____ Employer's Phone Number</p> <p>10 \$ _____ Employee's NET weekly salary as at date of injury <i>If self employed, please provide average weekly salary based on 12 month period directly prior to injury.</i></p> <p>12 What is the Employee's income definition <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Casual <input type="checkbox"/> Self Employed</p> <p>13 ____/____/____ Date Employee ceased work due to injury</p> <p>15 Has the Employee returned to work? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, what date?</i> ____/____/____</p> <p>16 During the period of incapacity has the employee received a salary? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, What for?</i></p> <p><input type="checkbox"/> Sick leave Salary received from ____/____/____ to ____/____/____</p> <p><input type="checkbox"/> Annual leave Salary received from ____/____/____ to ____/____/____</p> <p><input type="checkbox"/> Other Salary received from ____/____/____ to ____/____/____</p> <p><i>Net of business expenses, personal deductions and income tax. Payment excludes bonuses, commissions, and other allowances.</i></p>	<p>6 _____ Name of Contact Person</p> <p>9 ____/____/____ Date Employee commenced with the organisation</p> <p>11 () _____ Employer's Facsimile Number</p> <p>14 ____/____/____ Date expected to resume normal duties</p> <p>17 _____ If Employed - Salary Officer's Name (please print)</p> <p>_____ If Employed - Salary Officer's signature</p> <p>_____ If SELF EMPLOYED - Accountant's name (please print)</p> <p>_____ If SELF EMPLOYED - Accountant's signature</p>
	<p>_____ Salary Officer's Phone Number</p> <p>____/____/____ Date</p> <p>_____ Accountant's Phone Number</p> <p>____/____/____ Date</p>

***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.

CLAIM FORM SECTION D: PHYSICIAN'S REPORT (CONTINUED)

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

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

Physiotherapy _____
Treatments required

Chiropractics _____
Treatments required

Surgery _____
Treatments required _____
Please provide surgery details

Other: _____ _____
Please specify Treatments required Please provide details

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

17 What date do you advise the patient should return to Netball? _____
Date advised to return to Netball

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

Incapacity to Work Statement *Only complete this section if claiming for Loss of Income.*
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 _____ 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

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