JLT Sport Personal Injury Claim Form

Hockey Australia National Risk Protection Programme

Important Information

Who should use this claim form?

You should complete this form if:

- ☑ **Insured -** You are a participant, official or volunteer (Insured Person) of a Club/Association (the Insured) covered within the Hockey Australia National Risk Protection Programme; and
- ☑ **Injured -** You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned hockey-related event/activity ***on or after 31/12/2016***; and
- ☑ **Non-Medicare/Loss of Income -** You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme and/or have incurred time off work due to your injury.

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on JLT Sport's web site www.jltsport.com.au/hockey

What is covered?

The Hockey Australia National Risk Protection Programme's Personal Injury cover provides some reimbursement for Non-Medicare Medical costs and/or Loss of Income cover for 12 months from the date of injury.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Medicare Gap. Non-Medicare Medical Benefits are covered up to the limits outlined below.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS).

What are my levels of cover?

The following table outlines the reimbursement capacity for the cover within the Hockey Australia National Risk Protection Programme.

Non Medicare Medical Benefits	Loss of Income
75% reimbursement	80% reimbursement of gross weekly wage
$3,500 maximum per claim	Up to a maximum of $350 per week
$50 excess per claim	14 day elimination period / 52 week benefit period

What is NOT covered?

The following examples demonstrate some areas not covered by the Personal Injury cover:

- ☒ Medicare items (see below);
- ☒ the Medicare Gap (see below);
- ☒ Injuries sustained whilst playing against medical advice.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS) for further details.

What does "Non-Medicare" mean?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the "Medicare Gap".

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer or the JLT Trustee to reimburse any part of a Medicare Item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Hockey Australia National Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or www.medicare.gov.au

Please note: some Private Health Funds may offer Medicare Gap Insurance Cover. JLT Sport is not a Private Health Fund, nor do we offer Private Health Insurance.

WHAT'S COVERED?

NON-MEDICARE EXAMPLES:

Ambulance

Physiotherapist

Dental

Private Hospital Accom.

Chiropractor

WHAT'S NOT COVERED?

MEDICARE EXAMPLES:

Doctor

Surgeon

Surgeon's Assistant

Anaesthetist

X-Rays

Public Hospitals

Send completed forms to:

SUA Claims Department

sua@au.innovation-group.com

PO Box 2717

Taren Point ,NSW 2229

Or

Fax: (02) 9524 9003

Claims Enquiries:

Phone: 1300 363 413

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Claim Conditions

How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
   - Your claim form may be returned if there is important information missing
   - For assistance, please contact Sports Underwriting Australia(SUA) on 1300 363 413.
2. Send your completed claim form to **SUA Claims Department – sua@au.innovation-group.com or PO Box 2717, Taren Point, NSW 2229** within 180 days from the date of injury.
   - ***Do not*** wait until your treatments have concluded before you lodge your claim
   - You can lodge your claim even if you have no out of pocket expenses
3. SUA will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information
4. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to SUA as your treatment continues (for up to 12 months from the date of injury).

What should I send with my claim?

Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to SUA.

Retain a copy - Please submit only original receipts to SUA. We recommend you retain a copy of all receipts and your Claim Form for your records.

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send SUA a copy of your Private Health rebate advice.

Claims Conditions:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to SUA within 180 days from the date of injury.

Subject to the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by SUA must be provided by you upon request and at your expense (if applicable).

Who is JLT Sport?

JLT Sport is the appointed broker for the Hockey Australia National Risk Protection Programme. As a division of Jardine Lloyd Thompson Pty Ltd, JLT Sport is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries

Privacy:

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other JLT products or services. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and JLT related Group companies. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- By providing the information requested in the attached document, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- If you do not provide all or part of the information requested, we may be unable to process your application or provide other required services, your application for insurance may be declined or you may prejudice your insurance cover.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided, as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent.

For further information contact your JLT Client Risk Adviser or the JLT Privacy Officer:
Jardine Lloyd Thompson Pty Ltd, 66 Clarence Street, SYDNEY NSW 2000 Telephone: (02) 9290 8000

Complete ALL sections

Send within 180 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

Send completed forms to:

SUA Claims Department

sua@au.innovation-group.com

PO Box 2717

Taren Point ,NSW 2229

Or

Fax: (02) 9524 9003

Claims Enquiries:

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Section A: Claimant's Details

PERSONAL INFORMATION:

Claimant's Name: First Name _____ Surname _____

Postal Address: Street Address _____ State _____ Postcode _____

Occupation: _____

Contact Details: Email Address _____ Phone Number (Bus. Hours) _____

Personal Details: Date of Birth / / ○ Male ○ Female Gender — Date of Injury / / — Time of Injury AM / PM

Club Name: _____

Association Name:

Describe your injury and how it happened (please attached additional pages if required):

INJURY RESEARCH DATA:

When did the injury occur? ○ Warm Up ○ Warm Down ○ Training/Lesson ○ Competition/Event ○ Other_____

Level of involvement? ○ Club ○ State ○ National ○ International ○ Other_____

Injured Person? ○ Player/Participant ○ Coach ○ Umpire ○ Club Volunteer ○ Other_____

How did the injury occur? ○ Fall / trip ○ Running ○ Hit by stick ○ Collision ○ Overuse ○ Hit by ball ○ Other _____

Resumption date(s): When will you resume WORK? / / When will you resume TRAINING? / / When will you resume PLAYING? / /

Private Health Cover: ○ Yes ○ No — Do you have Private Health Insurance? — If YES, what is the name of your Private Health Insurance Provider? _____

Private Health Coverage: ○ Dental ○ Physiotherapy ○ Ambulance ○ Hospital

Ambulance Membership: ○ Yes ○ No

PAYMENT DETAILS:

Payee details: ○ Myself ○ Other — To whom should we make payment? — Payee Name/Account Name _____ ○ EFT (Direct Deposit) ○ Cheque — How would you like to receive payment?

BSB Number _ _ _ _ _ _ Account Number _____ Payee Postal Address _____

CLAIMANT DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. The injury was sustained accidentally during a hockey activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/hockey.

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).

D. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, and the Claims Managers.

E. You authorise any hospital, physician, Private Health and/or Income Protection insurers, or other person who has attended to your injury, or any employer, to furnish JLT's representatives with 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 employment records.

F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

G. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.

H. You authorise any and all information regarding claims with any other insurer to be released to JLT's representatives

Claimant's Signature* _____ Date: / /

Parent or Guardian if under 18 years

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sua@au.innovation-group.com

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Taren Point ,NSW 2229

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Section B: Club Declaration

CLUB DETAILS:

Claimant's Name: First Name _____ Surname _____

Club Name: _____

Club Contact: Club Contact Person _____ Position within Club _____

Contact Details: Contact Phone Number _____ Email Address _____

Association Name: _____

Registration Details: ○ Yes ○ No

INJURY DETAILS:

Date/Time: / / Date of Injury _____ AM PM Time of Injury _____

Circumstances: ○ Playing ○ Training ○ Travelling ○ Other

Opposition Club Name: _____ If applicable

Location: _____ Where did the injury occur?

Resumption date(s):

○ Yes ○ No Has the Claimant returned to RESTRICTED TRAINING? / / If YES, date Claimant returned?

○ ○ Has the Claimant returned to FULL TRAINING? / / If YES, date Claimant returned?

○ Yes ○ No Has the Claimant returned to COMPETITION? / / If YES, date Claimant returned?

CLUB DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).

B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.

C. You declare the Claimant's injury was sustained accidentally during a hockey activity noted above and is not a pre-existing illness or condition.

D. You understand that registering your club with JLT Sport is a requirement of the Hockey Australia National Risk Protection Programme for each Period of Cover.

E. You confirm the club's level of cover as per the details provided above.

Club Representative's Signature: _____ Date: / /

For Coverage details, please refer to JLT Sport's web site.

www.jltsport.com.au/hockey

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Section C: Loss of Income

TO BE COMPLETED BY THE CLAIMANT:

Do you wish to claim Loss of Income Benefits? ○ Yes ○ No If NO, proceed to SECTION D

Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)? ○ Yes ○ No

Have you ever made previous claims in respect to a personal injury insurance policy or plan? ○ Yes ○ No

Have you engaged in any other income earning employment since you became injured? ○ Yes ○ No

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):

Claimant's Name: _____ (First Name) _____ (Surname)

Employer/Business: _____ (Employer/Company Name) _____ (Contact Person)

Postal Address: _____ (Street Address) _____ (State) _____ (Postcode)

Contact Details: _____ (Email Address) _____ (Phone (Bus. Hours)) _____ (Mobile)

Employment Status: ○ Full Time ○ Part Time ○ Casual ○ Self Employed

Employment Details: $ _____ (Employee's NET weekly salary) $ _____ (Employee's GROSS week salary) _____ (Date Employee commenced with company.)

If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.

Injury Details: _____ (Date employee ceased work) _____ (Date expected to resume duties)

Returned to Work: ○ Yes ○ No _____ (Has the Employee returned to work? / If YES, what date did the Employee return?)

Salary Received: ○ Yes ○ No If YES, what for?

During the period of incapacity, has the employee received a salary?

Sick Leave: ○ Yes ○ No from / / to / /

Annual Leave: ○ Yes ○ No from / / to / /

Other: ○ Yes ○ No from / / to / /

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived from playing sport.

EMPLOYER'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are the Claimant's current employer (or accountant if the claimant is self-employed),

B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,

C. You will supply upon request any further information as required for the determination of this claim.

Employer's Signature: _____ Date: / /

** Accountant's signature (if claimant is self-employed)*

For more information, please refer to JLT Sport's web site:

www.jltsport.com.au/hockey

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Section D: Physician's Report

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT/SUA

PHYSICIAN'S REPORT

Claimant's Name: _____ (First Name) _____ (Surname)

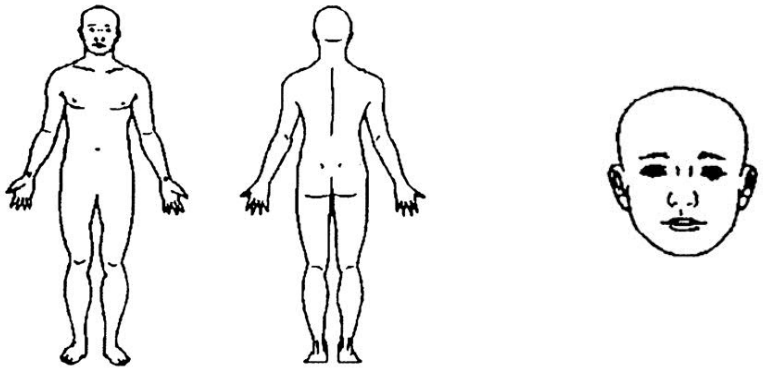
Physician's Details: _____ (Physician's Name) _____ (Phone Number)

Injury Consultation: ___/___/___ (Date of Injury) ___/___/___ (Date of Consultation)

Diagnosis/History of injury:

Injury Location:
○ Ankle ○ Arm ○ Dental ○ Facial ○ Foot
○ Hand ○ Head ○ Internal ○ Knee ○ Lower Leg
○ Shoulder ○ Spinal ○ Torso ○ Upper Leg

Please mark (×) the anatomical location below:



Injury Type:
○ Amputation ○ Bruising ○ Concussion ○ Cut ○ Death
○ Dental ○ Dislocation ○ Fracture/Break ○ Rupture ○ Sprain
○ Strain ○ Fatigue/Debilitation

First Medical Treatment: ___/___/___ (Date of treatment) _____ (Name of attending physician)

Do you consider the Claimant's injury to be a NEW injury? ○ Yes ○ No

Do you consider the Claimant's injury to a recurrence of a previous injury? ○ Yes ○ No

If YES, please provide details and a description:

Does the Claimant have any congenital defects or chronic deases? ○ Yes ○ No

If YES, please provide details and a description (dates, name of treating doctor, etc):

Please continue to Page 7.

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Sports Underwriting Australia

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Section D: Physician's Report

PHYSICIAN'S REPORT (continued)

Have you referred the patient to any other services or treatment? ○ Yes ○ No

If YES, please provide details below:

Physiotherapy: ○ Yes ○ No _____ If YES, approx. number of treatments required.

Chiropractics: ○ Yes ○ No _____ If YES, approx. number of treatments required.

Surgery: ○ Yes ○ No _____ If YES, please provide details

Other: ○ Yes ○ No _____ If YES, please provide details

Has the Claimant been able to do any work since the injury occurred? ○ Yes ○ No

What date do you advise the Claimant to return to participating in hockey? / /

If YES, please provide details

PHYSICIAN'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form;

B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Signature: _____ Date: / /

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT:

I, _____ (Medical Practitioner's Name) examined _____ (Claimant's Name) on / / (Date of examination)

In my opinion, this person is/has been unfit to work from / / (First day of incapacity) to / / (Last day of incapacity) inclusive.

Please provide any further comments in regard to your assessment of the injury/condition?

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form;

B. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature: _____ Date: / /

For more information, please refer to JLT Sport's web site:

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