



SPORTING ACCIDENT CLAIM

POLICY NUMBER: GP/00062/000/11/C

CLAIM NUMBER:

Claiming Notes:

- The issue of this form does not constitute an admission of liability on the part of the insurer.
- Government legislation does not allow refund of any part of a Medicare expense, that is doctor, surgeon, Anaesthetist, X-Ray and pathology. **DO NOT SEND ANY MEDICARE ACCOUNTS.**
- In the first instance, complete an Incident Report provided by your Club and lodge it with them within 30 days.
- Please complete this claim and forward to AIS Gold Coast Office – details as above.
- Do not wait for accounts before sending claim.
- Continue your treatment and forward itemised accounts and receipts.
- Claims without referral from a medical practitioner or dentist following injury will be denied.

PLAYER DETAILS:		
NAME:	Surname:	Given Names
ADDRESS:		
CONTACT DETAILS:	Home: ()	Work: ()
	Mobile:	Email:
OCCUPATION:		DATE OF BIRTH: / /
SPORT: Soccer	Club/Team	Association:
INJURY DETAILS		
Date of Injury:	/ /	Were you: Playing <input type="checkbox"/> Training <input type="checkbox"/> Travelling <input type="checkbox"/>
Time of Injury:		How did the injury occur: Collision <input type="checkbox"/> Tripped <input type="checkbox"/> Fell <input type="checkbox"/>
Give details of accident:		
Have you suffered this injury in the past	No <input type="checkbox"/> Yes <input type="checkbox"/>	Give Details:
Are you entitled to claim under any other personal accident policy or social security for this injury. No <input type="checkbox"/> Yes <input type="checkbox"/>		
HEALTH FUND MEMBERSHIP		
If you are a member of a Private Fund, you MUST claim on your fund first. Please forward fund statements with this claim.		
Are you a member of a Private Health Fund	No <input type="checkbox"/> Yes <input type="checkbox"/>	Name of Fund:
Membership No.		Have you elected Extra Cover ie Physio/Chiro/Dental No <input type="checkbox"/> Yes <input type="checkbox"/> Have you elected Hospital and Ambulance Cover No <input type="checkbox"/> Yes <input type="checkbox"/>
PRIVACY		
<p>DUAL Australia are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters. For more information about our Privacy Policy, please refer to: www.dualaustralia.com.au</p>		
INJURED PLAYER'S AUTHORISATION AND DECLARATION:		
<p>I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.</p> <p>I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original</p>		
Signature of Injured Player:		Date: / /
Please print your name:		

CLUB OFFICIAL DECLARATION			
This is a legal document and false declaration can result in legal implications for both the individual and the Club.			
I,		(Club Official) of	
		(Club)	
Certify that		(Player) sustained injuries resulting in this claim	
On		/ / (date) at (Time).	
Whilst training/playing at :		(field location)	
Club Mailing Address:			
Is the player a registered Player	No <input type="checkbox"/> Yes <input type="checkbox"/>	Registration No.	
Did the player appear on an official team player sheet?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Rate: Student <input type="checkbox"/>	Non Student <input type="checkbox"/>
Signature:	Date: / /		
Telephone No	Home:	Business:	Mobile:
INCOME AND EMPLOYMENT DETAILS - EMPLOYERS DECLARATION			
You must provide a Pay Summary Report for the 12 months prior to the date of the Injury			
EMPLOYER:			
ADDRESS			
Date Commenced with Employer	/ /	Dated Ceased Work Due to Injury	/ /
		Expected Resumption Date	/ /
Gross Weekly Income Prior to Injury	\$	Gross Annual Income	\$
Details of Payments During Time off work ie Holiday/Sick Leave:			
Paid from: / / to / /			
Salary Officer's Name:	Telephone No		
Salary Officer's Signature	Date: / /		
INCOME AND EMPLOYMENT DETAILS FOR SELF-EMPLOYED PERSONS			
You must provide all the details above on a Statutory Declaration and have it signed and witnessed by a Justice of the Peace. You must also advise on the Statutory Declaration whether or not you have any other personal Accident or Income Protection policy that you can claim on for this injury. If you do, you should advise the name of the Insurer and contact phone number, policy number, sum insured per week or per month, and the waiting period or excess. You must also send a copy of your last Tax Assessment Notice and Profit/Loss Statement.			
BANK ACCOUNT DETAILS FOR PAYMENT OF CLAIM			
BSB NO:		ACCOUNT NO:	
NAME OF ACCOUNT			

PHYSICIAN STATEMENT Must be completed by a dentist, doctor or surgeon, not by a physiotherapist or chiropractor. Any expense for the completion of this statement can only be met by the patient and not the insurer.	
Patient's Name:	Surname: _____ Given Names: _____
Condition: Give a Complete diagnosis of this condition	
History: When did the patient first suffer the injury?	Date: / / Time: am/pm
What did the patient tell you were the circumstances surrounding the injury?	
When did the patient first receive medical treatment?	Date: / /
When were you first consulted?	Date: / /
Was there a previous history of this or a similar condition?	No <input type="checkbox"/> Yes <input type="checkbox"/> When was treatment given?
Were there any structural deficiencies or weaknesses to this region prior to this injury that directly contributed to this injury?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Is there any underlying condition affecting recovery from the current condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>
If yes, advise nature of underlying condition and how it affects disability and recovery.	
DEGREE OF DISABILITY	
When was the patient obliged to cease work?	Date: / / Time: am/pm
If the patient is still disabled, when will the patient be able to resume.....	
-one or more of the material tasks of their occupation?	Date: / /
-all of the tasks of their occupation?	Date: / /
If the patient has recovered, when was the patient able to resume.....	
-one or more of the material tasks of their occupation?	Date: / /
-all of the tasks of their occupation?	Date: / /
A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK	

REFERRAL MUST BE COMPLETED FOR SUPPORTING SERVICES

Physiotherapy Chiropractic Osteopathic Massage Services Other:

Date Referred: / / No. of Treatments: No. of Weeks Review date for further referral / /

HOSPITAL DETAILSWas the patient confined to Hospital? No Yes Give Details:

Name of Hospital	Address	Period of Confinement: From: To:

OTHER DETAILS:**What are the current symptoms?****Give results of any objective findings?**

X-rays

Other Tests (specify)

What surgical procedures have been performed or are being contemplated?

Advise names and addresses of other treating physicians

Have you terminated treatment? No Yes

On: / /

What is the current prognosis:

Doctor's Name:

Address:

Telephone:

Signature:

Date: / /