SPORTS INJURY CLAIM FORM

NSW JUNIOR RUGBY LEAGUE

This information must be completed and signed by the **Injured Person,** a **Club Official** and your **District Administrator** and forwarded to **GAB Robins Australia** within 30 days of injury. **DO NOT** wait for all accounts/receipts before forwarding.

We may be unable to deal with your claim properly if you have not answered all questions fully.

IMPORTANT INFORMATION: PLEASE READ

IMPORTANT NOTE REGARDING CLAIMS FOR MEDICAL EXPENSES

We ***do not provide cover*** for any account that is fully or partially covered by Medicare. This means we do not cover expenses claimable from Medicare or the Medicare Gap. The reason for this is that the National Health Act 1953 does not permit us to do so. Please do not send us any account/receipt that is covered by Medicare or Medicare Statements. Do not wait for any account/receipt before sending.

We ***do cover*** Non Medicare medical expenses. We will pay the percentage amount shown in the Policy schedule of charges for Private Hospital, Dental, Ambulance, Chiropractic treatment, Physiotherapy, or any similar provider of medical services provided always that such treatment is certified necessary by a legally qualified medical practitioner.

HOW TO CLAIM MEDICAL EXPENSES ONLY

When claiming for Non Medicare medical expenses you must have the '***Sports Injury Report Form'*** fully completed.

Medical treatment must be certified necessary by a legally qualified medical practitioner. This could be your treating doctor or dentist. The ***'Attending Physician's Statement***' must be fully completed (without expense to the Insurer) prior to submitting a claim.

Please note that medical cover is ***limited for 12 months*** from the date of the accident.

For each and every claim a $100 excess will apply ($50 excess if in a Private Health Fund).

Please check with your Club for exact cover.

HOW TO CLAIM LOSS OF INCOME

When claiming for Loss of Income you must have the ***'Sports Injury Report Form'*** fully completed including the section to be completed by your Employer. If self employed you will need to attach proof of earnings such as a tax return.

The Policy has a 14 day elimination period, this means the first 2 weeks off work will not be reimbursed.

You must have your treating doctor complete the ***'Attending Physician's Statement***' (without expense to the Insurer) prior to submitting a claim.

Original medical certificates must be forwarded. We do not accept photocopies and the medical certificates must always be current.

If your disability is continuing, please forward medical certificates every two weeks. Loss of income benefits will not be paid until all statements and documents are submitted.

PLEASE REMEMBER

1. If you have Private Health Insurance, you must submit details to your insurer prior to claiming from us.
2. Attach original receipts/accounts for the treatment you are claiming.
3. Excesses and percentages of cover apply under the Policy.

It is suggested that you check these details with your Club/Association representative prior to submitting a claim to us.

Please return completed forms directly to:

GAB Robins Australia Pty Limited
PO Box 1438, Parramatta N.S.W 2150
Phone: 02) 9633 3533 Fax: 02) 9633 5521

QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035
Box 82 GPO Sydney NSW 2000
Telephone 02 9375 4444 Facsimile 02 9375 4885

Please return this form to – GAB Robins Australia Pty Ltd, PO BOX 1438, Parramatta N.S.W 2150
Telephone: 02 9633 3533 – Facsimile: 02 9633 5521

NSW Junior Rugby League – Sports Injury Report Form

Players Name:							
Address:					Post Code:		
Telephone:	Home -		Work -		Mobile -		
Date of Birth:		Height:		Weight:		Sex:	M / F
Normal occupation prior to disablement:							
Name of Club, Grade & Team:		Registration Number:		Position Played:			

DETAILS OF INJURY:

A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).

Type of Injury:		How did injury occur?	
Place where you were injured:			

Date of Injury:		Time:		Training:	Yes		No	Playing:	Yes		No

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition (s):		Date:		Treated By:	

To be completed by the Club Secretary/Treasurer.
Please ensure that all questions have been fully answered.

Name of Player			was injured as stated.
Grade with the Club			
Name of Club			
Secretary/Treasure's Name		Telephone	
Address		Post Code	

I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.

Signature		Date		Witness		Date	

District Administrator's Acknowledgment:	(Signature and Date)	*District:*	

Details of Non Medicare expenses claimed.
NB Only forward accounts for services which are not subject to a Medicare rebate
Ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

Are you a member of a private health fund? Yes No

If yes, which one?

Hospital Cover Yes No Extras covering dental, physio, etc. Yes No

Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)					
b)					
c)					
d)					

When did you first consult a physician for this condition?	
When did you become totally disabled (unable to work)?	
When were you able to again perform part of your occupational duties?	
If still totally disabled, when do you expect your disability to terminate?	
When will you resume training?	
Give name and address and period of stay at hospital (if applicable):	

Hospital	Addresses	From	To

a. Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

b. Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)

Name	Address	Telephone

LOSS OF INCOME CLAIMS:

1. IF SELF EMPLOYED

(Please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant?

Name	Address	Telephone

2. IF EMPLOYED AS A WAGE EARNER

(To be completed by your employer)

I HEREBY CERTIFY THAT:……has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on ……..

He/She has been incapacitated since……..and is expected to/did resume duties on ……

His/Her gross basic salary（excluding bonuses, commission and overtime)at the date of injury was –

$ …….per week.

During this period of incapacity he/she received:

a) Normal pay $…….. b) Sick pay $…….. c) Workers Compensation $…….
From ……. to …….. From ……. to ……..….. From …….. to ……..

d) Other (please specify) $…….
From…… to…….

He/She has been employed since……

His/Her sick leave entitlements at date of injury is …… days.

Name of Company: ……..

Address: ……..……

Name of Manager or Paymaster (Please Print): ……..……..

Signature of Manager or Paymaster: ……..…….

Telephone: ……. Date: …… Company Stamp:

Loss of Income Claims (cont'd)

Are you claiming or entitled to claim any other form of income (eg. Dept of Social Services, loss of income protection insurance, etc.)? If so, please provide details.

……..

……..

DECLARATION AND AUTHORISATION

I hereby authorise any hospital, physician or any other person who has attended me, or any employer, to furnish QBE Insurance (Australia) Limited or its representatives with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers including verification of earnings.

I acknowledge that any personal information that I have or will provide to QBE Insurance (Australia) Limited (QBE) is necessary for and will be used in the processing, assessing, investigation or review of this claim. I consent to QBE or its authorised agent to disclose my personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, broker, State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personal information (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, QBE will provide to me their dispute resolution procedures.

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.

Signature of Player: _____ **Date**: _____
(or parent/guardian if under 18 years of age)

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QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035
Box 82 GPO Sydney NSW 2000
Telephone 02 9375 4444 Facsimile 02 9375 4885

Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the company)

Patients Name		Address		Sex	M/F
What is disabling patient? (Please give a complete diagnosis of this condition)					

HISTORY:

1. When did patient first receive medical treatment?			
2. Was there a previous history of this or a similar condition?	Yes ☐	No ☐	
If yes, please state condition and advise when previous treatment given.			
3. a) How long have you known the patient?			
b) Are you the regular general practitioner? If no please advise who is?	Yes ☐	No ☐	

IF INJURY:

1. When did patient suffer the injury?	
2. What were the circumstances surrounding the injury?	

IF DISABILITY:

1. Patients occupation?			
2 When was patient obliged to cease work?			
3. If patient still disabled, when will the patient be able to commence any type of employment?			
a) some duties		b) full duties	
4. If patient has recovered, when was patient able to resume.			
a) some duties		b) full duties	

TREATMENT OF PRESENT CONDITION

1. When were you consulted?			
a) initially?		b) most recently?	
2. How often has patient consulted you?			
3. Was patient confined to hospital?	Yes ☐	No ☐	
If yes please advise Hospital Name			
Address			
Period of confinement	From	To	
4. Was confinement in a convalescent home necessary after hospitalisation?	Yes ☐	No ☐	
If yes please give details.			
5. What are the current subjective symptoms.			
6. Please give results of any objective finding.			
a) X-rays			
b) Other test - Please advise test done and findings			
7. What surgical procedures have been performed?			
8. What surgical procedures have been contemplated?			
9. What other treatment has the patient undergone?			
10. What other treatment is required?			
Are there any underlying conditions affecting recovery from the current condition?	Yes ☐	No ☐	
If yes please advise nature of underlying conditions and how they affect disability and recovery.			
Has patient any other physical or mental impairment?	Yes ☐	No ☐	
If yes, please describe.			
Please advise names and addresses of other treating physicians.			
Name	Address	Telephone	
If you have terminated treatment, please advise date.			
What is your current prognosis?			
Are there any further remarks which may assist in assessing this condition?			
Is there any permanent disability present?	Yes ☐	No ☐	
If yes, please explain giving estimated percentage of loss of function.			
Name (please print name):	Address:	Telephone:	
Signature:	Degree:	Date:	