Sports Underwriting Australia
Sports Injury Claim Form

Sports Underwriting Australia Claims Department

E: liabilityclaims@sportsunderwriting.com.au

Ph: 1300 363 413

Post: Level 7, 100 Arthur Street, North Sydney NSW 2060

IMPORTANT NOTICES

Your Duty of Disclosure

This Policy is subject to the Insurance Contracts Act 1984 (Act). Under that Act you have a Duty of Disclosure.

Before you take out insurance with us, you have a duty to tell us of everything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms. If you are not sure whether something is relevant you should inform us anyway.

You have the same duty to inform us of those matters before you renew, extend, vary, or reinstate your contract of insurance. The duty applies until the Policy is entered into, or where relevant, renewed, extended, varied or reinstated (Relevant Time). If anything changes between the time the answers are provided to us or disclosures are made and the Relevant Time, you need to tell us.

Your duty however does not require disclosure of matters that:

- reduce the risk;
- are common knowledge;
- we know or, in the ordinary course of our business, ought to know, or
- we have indicated we do not want to know.

If you do not comply with your duty of disclosure, we may be entitled to:

- reduce our liability for any claim;
- cancel the contract;
- refuse to pay the claim, or

avoid the contract from its beginning, if your nondisclosure was fraudulent.

Who Needs To Tell Us

It is important that you understand that you are answering our questions in this way for you and anyone else whom you want to be covered by the Policy.

Dispute Resolution Process

If you are not satisfied with our service please tell us so we can help. We will address complaints in accordance with Great Lakes Australia's Complaints Handling Process and the Insurance Council of Australia's Code of Practice.

If you have a complaint:

Step 1: Contact us

You can contact us by:

Postal Address: PO Box 288, Kew East Victoria. Australia 3102
Tel: +61 3 8862 2600
Email: info@sportsunderwriting.com.au

If we require additional information we will contact you to discuss. If your complaint is not immediately resolved we will respond within 15 business days of receipt of your complaint or agree on a reasonable alternative timetable with you.

Step 2: Internal Dispute Resolution

If you are not satisfied with our response you may refer it in writing to our Internal Dispute Resolution panel, which is independent of the original complaint review.

E-mail: disputes@gla.com.au
Postal Address: Attn: Dispute Resolution Officer
Great Lakes Australia PO Box H35 Australia Square NSW 1215

The panel will respond within 15 business days. If the panel cannot respond within 15 business days, the panel will agree a reasonable alternative timetable with you. If the panel cannot reach an agreement on an alternative timetable, the panel will advise you of your right to take your complaint to the FOS.

Step 3: External Dispute Resolution scheme

If we are unable to resolve your complaint within 45 days of the date we first received your complaint or if you remain unsatisfied, you can seek a free review by the FOS. The FOS is an independent national body and we agree to accept its decision.

You can contact the FOS by:

Postal Address: Financial Ombudsman Services Australia Ltd, GPO Box 3, Melbourne VIC 3001
Tel: 1800 367 287
Email: info@fos.org.au
Website: www.fos.org.au

Privacy Statement

In this Privacy section "we", "us" or "our" means Great Lakes Australia and Sports Underwriting Australia, unless specified otherwise.

We are committed to the safe and careful use of your personal information in the manner required by the Privacy Act 1988 (Cth) and the Australian Privacy Principles.

We collect your personal information in order to assess your application for insurance and, if your application is accepted, to administer and manage your Policy and respond to any claim that You make. To do this, your personal information may need to be disclosed to reinsurers and service providers and related entities who carry out activities on our behalf, such as assessors and facilitators, some of whom may be located in overseas countries. Our contractual arrangements generally include an obligation for these reinsurers, service providers and related entities to comply with Australian privacy laws.

By providing us with your personal information, you consent to the disclosure of your personal information to reinsurers, service providers and related entities in overseas countries to enable us to assess your application, to administer and manage your Policy and to respond to any claim that you make. If you consent to the disclosure of your personal information to overseas recipients, and the overseas recipient handles your personal information in a way other than in accordance with the Australian privacy laws, we may not be responsible for the handling of your personal information by the overseas recipient.

If you choose not to provide your personal information and/or choose not to consent and / or withdraw your consent to the disclosure of your personal information at any stage, we may not be able to assess your application or administer and manage your insurance policy and respond to any claim that you make.

Our Privacy policies contain information on how you may access personal information that each of us hold, or seek correction of Your personal information and information on how to make a complaint about the handling of your personal information and how complaints are handled. If you require more information, you can access the Great Lakes Australia Privacy Statement at www.munichre.com/io/gla/en/privacy_statement.aspx and SUA Privacy Policy and Privacy Statement at www.sportsunderwriting.com.au/documents.html.

Taxation Information

The amount of cover available under this Policy excludes Goods and Services Tax (GST).

If you are not registered for GST, in the event of a claim we will reimburse you the GST component in addition to the amount that we pay.

The amount that we are liable to pay under this Policy will be reduced by the amount of any input tax credit that you are or may be entitled to claim for the supply of goods or services covered by that payment.

If you are entitled to an input tax credit for the Premium you must inform us of the extent of that entitlement at or before the time you make a claim under this Policy. We will not indemnify you for any GST liability, fines or penalties that arise from or are attributable to your failure to notify us of your entitlement (or correct entitlement) to an input tax credit on the Premium.

If you are liable to pay an Excess under this Policy, the amount payable will be calculated after deduction of any input tax credit that you are or may be entitled to claim on payment of the Excess.

If you are unsure about the taxation implications of this Policy, you should seek advice from your accountant or tax professional.

Members Name:									
Address:						Post Code:			
Telephone:	Home -		Work -		Mobile -				
Email:									
Date of Birth:			Height:		Weight:		Sex:	M / F	
Normal occupation prior to disablement:									

Name of Club, Grade & Team:	Membership Number:	Period/Expiry of Membership

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 Member			was injured as stated.
Type of Member			
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	

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 playing?	

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: .... Company Stamp:

Address: ....

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

Signature of Manager or Paymaster: ....

Telephone: .... Date: ....

Are you claiming or entitled to claim any other form of benefit (eg. Work Cover, Superannuation Injury Cover, etc.)? If so, please provide details.

....

....

Declaration

I declare that, to the best of my knowledge and belief, the information in this form is true and correct and I understand the claim may be refused or reduced if information is withheld.

I understand that I may have to provide relevant documentation to enable complete consideration of my claim.

I consent to Great Lakes Australia and Sports Underwriting using the personal information I have provided on this form for the purposes of processing my claim. I consent to the disclosure of sensitive information to third parties in order to process my claim. I consent to the disclosure of any personal information (including sensitive information) overseas where it is reasonably necessary for the processing of my insurance claim. I understand that if this consent is not given Great Lakes Australia and Sports Underwriting will not be able to process this insurance claim.

Signature of insured or person with authority to sign for and on behalf of a company or partnership.

Signature: ____ Date: ___ /___ /________

Please indicate the number of additional pages attached to this claim form: __________

Attending Physicians Statement

To be completed by a registered medical practitioner

(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: