V-INSURANCE GROUP

Office use only
Policy Number: S2000001802
Claim Number:

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone: (02) 8256 1770 Fax: (02) 8256 1775
Email: claims@csnet.com.au

V-INSURANCE GROUP

INSURANCE BROKER FOR NETBALL AUSTRALIA;
Authorised Representative No. 432898 a corporate
authorised representative of Willis Towers Watson AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547
Email: netball@vinsurancegroup.com

7. Once you have fully completed all sections of the claim form, please have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.

8. Please forward the entire form with supporting documentation to Corporate Services Network. They handle all claims for the insurer. Their contact details are as follows;

Corporate Services Network
GPO Box 4276
SYDNEY NSW 2001
Phone (02) 8256 1770
Fax (02) 8256 1775
Email claims@csnet.com.au

9. Your reimbursement payment will be made by Corporate Services Network by direct deposit or cheque.

10. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network (Claims Services) can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

11. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance Group Team on ph: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Association Name(compulsory): Club Name:	Member No (if applicable):	Claimant's Given Name: Surname:
Name of team/age group/grade:		
Gender (please tick): ❑ Male ❑ Female	Occupation:	Date of Birth: / /
Address State Postcode		Email:
Phone Number (work): ( )	Home: ( )	Mobile:

Please tick the category applicable ❑ Player ❑ Official ❑ Coach ❑ Umpire ❑ Other

If Other, please advise _____

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I_____(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Liberty 6 S H F L D O W to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information Liberty 6 S H F L D O W and their service providers in order to assess the claim. Liberty 6 S H F L D O W complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant _____ Date_____

(or Legal Guardian if under 18 years of age)

DECLARATION BY ASSOCIATION/CLUB

Name of Association/Club:	Name of Association/Club Official making this statement:
Official Position:	Telephone Number: ( ) Email:
Address State Postcode	

I, the above mentioned Netball Australia Club Official, confirm that the claimant was a registered and Financial member of this Netball Australia Club and was an insured person as identified in the Personal Accident Insurance with Liberty Specialty Risks at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ❑ Yes ❑ No

If yes, please detail below

_____

Dated: / /	Signature of Association/Club Official:

Office use only
Policy Number: S2000001802
Claim Number:

ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury?

When did your accident occur?
Date: / / Time: am/pm

Was your activity at the time of the accident? (please tick)	Officially organised competition	❑
	Officially organised training	❑
	Social or private competition	❑
	Travelling to and from activity	❑
	Sanctioned fundraising/social event	❑
What type of Netball activity were you participating in? (please tick)	Netball Association / Club Activity	❑
	Fast 5 Netball	❑
	NetFest	❑
	Social Netball Training / Competition	❑

Please provide the address of where the injury occurred?

State the name of any one witness to the injury:	Address of Witness:
Person to whom accident/incident reported?	Date and time reported? Date: / / Time: am/pm

Brief summary of treatment/action taken at the time of the accident/incident?

Was hospitalisation required?	If yes, please advise the name of hospital?
If admitted into hospital, how long were you there?	Name of person who gave treatment?
Do you have Private Health Insurance?	If yes, please give fund name?

Advise when you did (or expect to):	Cease work/normal activities	_____
	Cease training	_____
	Cease participating	_____
	Resume work/normal activities	_____
	Resume training	_____
	Resume participating	_____

Have you ever had this injury or similar injuries in the past? Yes/No	If yes, please advise when? / /

The following information is required for Netball Australia research to assist with Risk Management, <u>answering these questions will not affect your claim</u>		
Where did your injury occur? (please tick)	Indoor	❑
	Outdoor	❑
Surface at point of injury? (please tick)	Timber	❑
	Synthetic	❑
	Concrete / Asphalt	❑
	Other, please advise……	❑
Weather conditions? (please tick)	Fine	❑
	Rain	❑
	Showers	❑
	Extreme Heat	❑
	Extreme Cold	❑
Surface Conditions? (please tick)	Wet	❑
	Dry	❑
	Other, please advise……	❑
Quarter/half injured? (please tick)	1st Quarter	❑
	2nd Quarter	❑
	3rd Quarter	❑
	4th Quarter	❑
	Not applicable	❑

LOSS OF INCOME

YOU MUST COMPLETE THIS SECTION & THE TAX FILE NUMBER DECLARATION FORM IF YOU ARE CLAIMING FOR LOSS OF INCOME

	(please tick Yes	No
1. Can compensation be claimed under worker's compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER/SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer: State Postcode	
Date ceased work due to injury: / /	Date expected to resume normal duties: / /
Employee weekly salary as at date of injury: Net $..... Gross $..... If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

❑ Self Employed ❑ Full Time ❑ Part Time ❑ Casual

During the period of incapacity the employee has received

$.....	Normal Pay	From	……/……/……	to	……/……/……
$.....	Sick Pay	From	……/……/……	to	……/……/……
$.....	Workers' Compensation	From	……/……/……	to	……/……/……
$.....	Other (please specify)	From	……/……/……	to	……/……/……

Has the employee returned to work? ❑ Yes ❑ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ❑ Yes ❑ No

A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountant's Company Stamp:	Date: / /

Australian Government
Australian Taxation Office

Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
- Print **X** in the appropriate boxes.
- Read all the instructions including the privacy statement before you complete this declaration.

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 2, 4b)

ato.gov.au

Section A: **To be completed by the PAYEE**

1 What is your tax file number (TFN)?

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN. ☐

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax. ☐

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance. ☐

2 What is your name? Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname or family name

First given name

Other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

4 What is your date of birth? Day / Month / Year

5 What is your home address in Australia?

Suburb/town/locality

State/territory Postcode

6 On what basis are you paid? (Select only one.)

Full-time employment ☐ Part-time employment ☐ Labour hire ☐ Superannuation or annuity income stream ☐ Casual employment ☐

7 Are you an Australian resident for tax purposes? (Visit **ato.gov.au/residency** to check) Yes ☐ No ☐

8 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Yes ☐ No ☐ Answer **no** here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions. No ☐

10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093). No ☐

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

(b) Do you have a Financial Supplement de

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

DECLARATION by payee: *I declare that the information I have given is true and correct.*

Signature

You MUST SIGN here

Date Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Once section A is completed and signed, give it to your payer to complete section B.

Section B: **To be completed by the PAYER** (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number?

30 074 864 609

Branch number (if applicable) 004

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes ☐ No ☐

3 What is your legal name or registered business name (or your individual name if not in business)?

CORPORATE SERVICES

4 What is your business address?

Suburb/town/locality

State/territory Postcode

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 02 8256 1770

6 If you no longer make payments to this payee, print X in this box. ☐

DECLARATION by payer: *I declare that the information I have given is true and correct.*

Signature of payer

Date Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Return the completed original ATO copy to:
Australian Taxation Office
PO Box 9004
PENRITH NSW 2740

IMPORTANT
See next page for:
- payer obligations
- lodging online.

Sensitive (when completed)

30920716

NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

Are you a member of an Ambulance Service? ❑ Yes ❑ No

Are you a member of a Private Health Fund? ❑ Yes ❑ No

If yes, please provide details .....

Hospital Cover? ❑ Yes ❑ No

Extras covering Physio etc ❑ Yes ❑ No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
				Total	
				Less Excess	
				TOTAL AMOUNT OF CLAIM	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor:.....

Address:.....

V-INSURANCE GROUP

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AR No. 432898 Willis Australia Limited AFSL: 240600
Phone (02) 8599 8660 or local call cost only 1300 945 547
Completed claim forms should be sent to
Corporate Services - claims@csnet.com.au,
GPO Box 4276, Sydney NSW 2001

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.**
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN/PHYSIOTHERAPIST

Patient's Full Name:	How long have you known the patient?

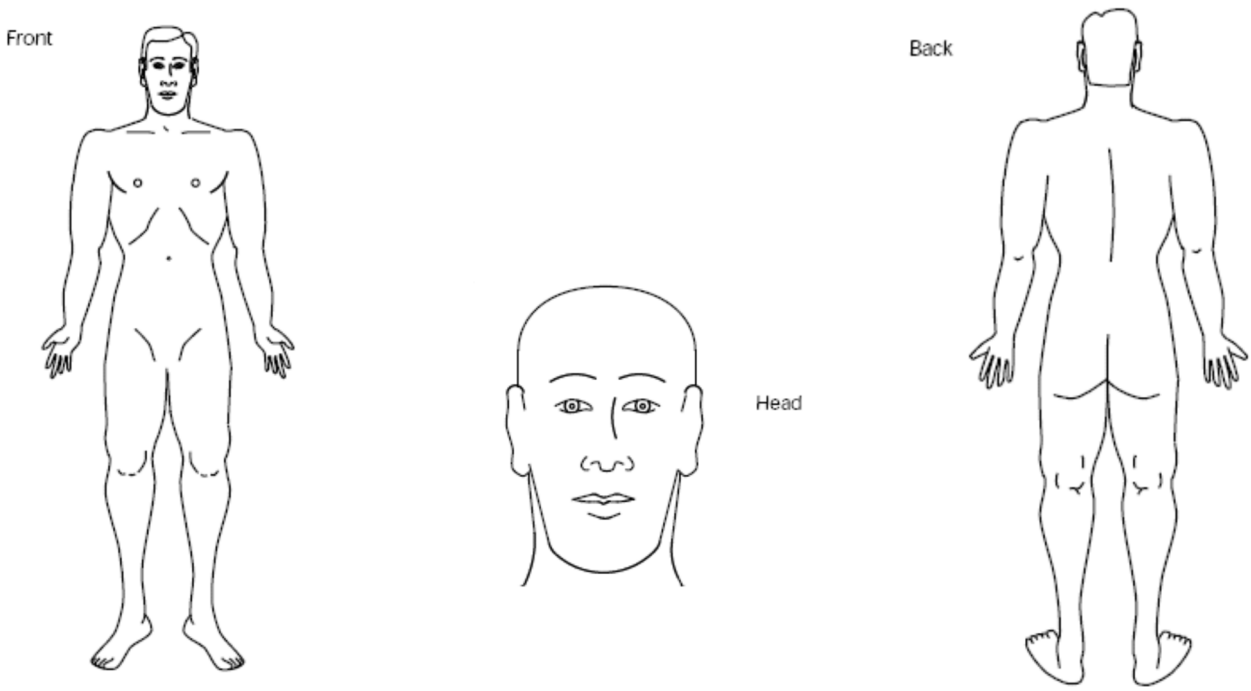
What date and where were you first consulted by the patient in connection with the present injury? / /

Patient's Occupation:

Are you the patient's regular general practitioner? ☐ Yes ☐ No

If not, please advise who is .....

What is the exact nature of the present injury?



Do you consider the patient's injury to be a new injury? ❑ Yes ❑ No

A recurrence of an old injury? ❑ Yes ❑ No

If yes, please state condition and advise when previous treatment was given .....

.....

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

Please specify the type and approximate number of treatments required:

❑ Physiotherapy .....

❑ Chiropractic .....

❑ Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated? .....

Are there any further remarks which may assist in assessing this condition? .....

.....

Is there any permanent disability at present? ❑ Yes ❑ No

If yes, please explain giving estimated percentage loss of function .....

.....

Was the patient obliged to cease work? ❑ Yes ❑ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to netball?

Does the patient have any congenital defects or chronic diseases? ❑ Yes ❑ No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital:	Date Admitted	Date Released
	/ /	/ /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....

METHOD OF PAYMENT

Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account

Please indicate your preferred method of payment (please tick) ❑ Cheque ❑ EFT

If you would like your payment made by EFT, please complete the details below.

NAME OF CLAIMANT

Title: ❑ Mr ❑ Mrs ❑ Ms ❑ Miss

Name:_____

BANK ACCOUNT DETAILS

BSB number (all 6 digits are required here) Account Number

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch:_____

DECLARATION BY CLAIMANT (OR GUARDIAN IF CLAIMANT UNDER 18)

I hereby authorise Corporate Services Network as agents of Liberty Specialty Risks to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment.
- Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network's disclosure of this information, to Corporate Services Network's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988.* I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.
- I agree that my personal information may also be shared with Netball Australia's insurance brokers, V-Insurance Group.

Signature: _____ Date: _____

Print Name: _____