ATC INSURANCE SOLUTIONS

CLAIM FORM

Sports Injury

EXTF04820140311

Call ATC for assistance on 1800 994 694

1. **You** complete Section A and B.

2. If you have a 'Non Medicare Expense' claim, you should also complete Section C. You should only submit this section of the form if you have completed all treatment, and no further treatment is required.

3. Your **Sports club** completes Section D.

4. Your **Medical practitioner** completes Section E.

5. If you wish to claim for loss of earnings, your **Employer** completes Section F.
   Should you be self employed, please ask your accountant to provide a written statement confirming your pre-tax earnings for the 52 weeks immediately prior to your injury.

6. If you went to hospital following an injury, attach a copy of the hospital admission notes.

7. Check all questions have been answered (including by selecting either 'Yes' or 'No' wherever this option is given) and each Section has been signed and dated.

   Your claim will be delayed if we have to return your claim form to you because it is incomplete.

8. Please keep a copy of the completed claim form and attachments for your records.

9. Send, or fax, or scan and email, or deliver your completed form in person to:
   ATC Insurance Solutions Pty Ltd
   Level 9, 499 St Kilda Road,
   Melbourne VIC 3004
   Fax: (03) 9867 5540
   Email: info@atcis.com.au

Important Information

Please read the following information carefully, prior to completing this ATC Insurance claim form.

1. **Assistance with Completing the Claim Form**

   Call our dedicated claims team on 1800 994 694 during business hours.

2. **Claim Assessment**

   – Every claim is unique and the assessment time will depend on the complexity of your medical condition and how quickly we can obtain all the information required to process the claim.

   – You can help prevent any unnecessary delays by ensuring all relevant questions in the claim form are answered and any additional documentation is provided as quickly as possible.

   – Assessment of your Non Medicare Expenses claim can only commence after treatment has been completed, all accounts have been paid and refunds obtained from your Private Health Insurer/Fund. Original receipts and Private Health Fund statements must be provided.

3. **Waiting Periods**

   All claims for 'Weekly Benefits' have a waiting period, during which no benefits are payable. Please refer to your club or association's policy for specific details.

4. **Medical Certificates**

   – Valid medical certificates are required for any period of incapacity.

   – A valid medical certificate must include:
   - Your medical practitioner's name and signature
   - Your name
   - The full cause of your incapacity (i.e. John Smith is suffering from a broken left ankle)
   - The start and end dates of your incapacity.

5. **Additional Documentation Required**

   If you were, or will be, admitted to hospital, please provide copies of any documentation you are provided with, such as admission notes, test results and discharge information.

6. **Privacy**

   In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

   We are bound by the requirements of the *Privacy Act 1988* (Cth), the *Privacy Amendment (Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

   Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

   We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

   We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

   Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

   - you have the authority from them to do so and it is as if they provided it to us;
   - you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

   You are entitled to access your information and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1777 or write to us at the address given on page 1.

SECTION A ➲ Claimant's Section (claimant to complete)

Surname: _____ Given Names: _____

Sex: Male ◯ Female ◯ Date of Birth: ____ /____ /_____ Height: _____ cm Weight: _____ kg

Street Address: _____

Suburb: _____ State: _____ Postcode: _____

Postal Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Telephone: _____ Mobile Telephone: _____

Email: _____

What is your preferred method of communication (telephone, postal or email)? _____

1. Can you claim against any of the following for this injury (select either Yes or No)?:

a) Workers' Compensation insurance Yes ◯ No ◯

b) Motor accident compensation insurance Yes ◯ No ◯

c) Sick leave (including portable sick leave) Yes ◯ No ◯

d) Centrelink and/or Government disability benefits Yes ◯ No ◯

e) Your employer or another party Yes ◯ No ◯

f) Superannuation fund Yes ◯ No ◯

g) Any other insurance policy (Travel, Income Protection etc) Yes ◯ No ◯

2. If you have answered Yes to any of the questions under 1, please provide further details (including the insurer's name and your claim number): _____

_____

3. Superannuation fund name and membership number: _____

Electronic Funds Transfer

If ATC approves your claim and you wish to have your claim benefits transferred directly to your bank account, please provide the following details:

Bank Name: _____ Bank Branch: _____

Account Name: _____ BSB: ___–___ Account No.: _____

Authority

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims, claims with any other insurer, or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

Declaration

I declare that:

a. the claim I am making for injury or sickness IS NOT WORK-RELATED and if my injury or sickness is work-related, I have disclosed this clearly in my answers, and;

b. my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.

Signature: _____

Name (Print): _____ Date: ____ /____ /_____

ATC Insurance Solutions Pty. Ltd. Telephone (03) 9258 1777 Fax (03) 9867 5540 Email info@atcis.com.au Web www.atcis.com.au

SECTION B ➔ Injury Statement (claimant to complete)

1a. Date of injury: _____ /_____ /_____ **1b.** Time of injury: _____ am/pm

2. On what date did you first seek medical treatment or advice? _____ /_____ /_____

3. On what date were you first unable to carry out your normal duties because of your injury? _____ /_____ /_____

4. In your own words describe your injury and how it happened? _____

_____

_____

5. What part of your body was injured? _____

_____

_____

6. Please tick the boxes which best describe the location and conditions of your injury:

a) Session: Playing ◯ Training ◯ Travelling ◯ Event ◯ Other ◯

If Other, please elaborate: _____

b) Injured Person: Junior Player ◯ Senior Player ◯ Umpire ◯ Official ◯ Trainer ◯ Other ◯

If Other, please elaborate: _____

7. Provide the location, including street address (if applicable), of where the incident occurred: _____

_____

8. Were there any witnesses to the incident? Yes ◯ No ◯

Witness name/s and contact number/s: _____

_____

9. Did you report the injury/incident to a sports club representative/official? Yes ◯ No ◯

Date reported: _____ /_____ /_____ Time reported: _____ am/pm

Club representative name/s and contact number/s: _____

_____

10. Provide details of your General Practitioner (GP) and all other medical practitioners seen for your current injury.

PRACTITIONER'S NAME	FIRST DATE OF ATTENDANCE	SPECIALTY	PHONE	FAX
GP:	/ /			
	/ /			
	/ /			
	/ /			

11. Have you ever had a similar injury before? Yes ◯ No ◯ If Yes, please describe the injury, when and how it happened and whether there is any connection between the previous injury and the current injury and list any medical consultations below:

_____

_____

_____

PRACTITIONER'S NAME	FIRST DATE OF ATTENDANCE	SPECIALTY	PHONE	FAX
GP:	/ /			
	/ /			

12. Is your current incapacity caused by a recurrence of a condition you have suffered in the past? Yes ◯ No ◯

If Yes, please advise when you were first diagnosed with this condition? _____

13. When will you (expect to) resume your pre injury work duties? _____ /_____ /_____

When will you (expect to) resume training? _____ /_____ /_____

When will you (expect to) resume playing? _____ /_____ /_____

14. Please give as much detail as possible about the type of treatment you are receiving: _____

_____

_____

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SECTION C ➲ Non Medicare Expenses (claimant to complete)

Please only complete once your medical treatment has been fully completed and no further treatment is required or claimable.

Please note that ATC Insurance Solutions is a NON MEDICARE MEDICAL INSURER and in accordance with the Health Insurance Act 1973, we are not permitted to provide cover for the MEDICARE GAP. This means that in most cases, this policy will not cover a service that is performed by a Registered Medical Practitioner such as a Doctor, Surgeon, Anaesthetist, Pathologist and Radiologist.

We will not pay for any of the following expenses under this section:
- any expenses covered by the Medicare Act 1983 or a private health arrangement
- any expenses which can only be covered by an authorised health insurer
- any expenses incurred after 12 months from the date of the Accident
- any amount over the percentage of expenses or maximum sum insured stated in the Schedule
- any expenses incurred after the Benefit Period stated in the Schedule.

Please only forward accounts for services which are not subject to a Medicare rebate.

1a. Do you have Private Health Cover? Yes ◯ No ◯

If Yes, please specify the name of your Private Health Insurance Provider: _____

If you have answered No to question 1a, please move onto Question 2.

1b. Hospital Cover: Yes ◯ No ◯

Extras Cover including dental, physio etc.: Yes ◯ No ◯

2. Do you have an Ambulance Membership: Yes ◯ No ◯

3. Was an ambulance called? Yes ◯ No ◯

4. Were you hospitalised due to this injury? Yes ◯ No ◯

5. If so, which hospital were you admitted to and when were you discharged? _____

_____

_____

6. Please provide a list of treatments for which you wish to claim a reimbursement.

DATE OF TREATMENT	NAME OF PROVIDER	TYPE OF SERVICE	AMOUNT IN $	HEALTH FUND REBATE	AMOUNT CLAIMED
a) / /					
b) / /					
c) / /					
d) / /					
e) / /					
f) / /					

Please ensure the service provider's original invoice and Private Health Fund rebate statement is attached to this claim form in order to assist us in the assessment of your Non Medicare Expenses claim.

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SECTION D ➔ Sports Club Declaration (Club President / Secretary / Treasurer to complete)

Club Details

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

Club status of Claimant: Junior member ◯ Senior member ◯

Club Name: _____

Club Contact: _____ Position within Club: _____

Email address: _____ Contact telephone number: _____

League Name: _____

Club address: _____

Suburb: _____ State: _____ Postcode: _____

Injury Details

Date of injury: ____ /____ /_____ Time of injury: _____ am / pm

Circumstances: Playing ◯ Training ◯ Travelling ◯ Other ◯

If Other, please explain: _____

Has the claimant returned to training? Yes ◯ No ◯ Not applicable ◯

If Yes, please confirm the date the claimant returned to training: ____ /____ /_____

Has the claimant returned to competition? Yes ◯ No ◯ Not applicable ◯

If Yes, please confirm the date the claimant returned to training: ____ /____ /_____

Club Declaration

By signing the declaration below, I hereby confirm and agree that:

1. **I am authorised in my duties to the above mentioned Sports Club to act on behalf of the Club in relation to insurance matters**
2. **I am independent of the claimant (ie not a family member)**
3. **I confirm that the Claimant is a member of the above named Club**
4. **I confirm the injury details supplied herein are true and accurate to the best of my knowledge**
5. **I declare that the Claimant's condition was sustained accidentally during the sporting activity noted above.**

Signature: _____

Name (Print): _____ Date: ____ /____ /_____

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SECTION E ➲ Medical Practitioner's Statement

Important: All questions in Section E must be completed in full by a medical practitioner. The claimant is responsible for any fee for this statement. Please provide as much detail as possible.

Claimant's Full Name: _____

Sex: Male ◯ Female ◯ Date of Birth: _____ /_____ /_____

1. Date of injury (if applicable): _____ /_____ /_____

2. Date of onset of first symptoms of the claimant's condition: _____ /_____ /_____

3a. Date you were first consulted for this condition: _____ /_____ /_____

3b. Date of actual diagnosis of the claimant's condition: _____ /_____ /_____

4. What is your current diagnosis of the claimant's condition? _____

_____

_____

5. Are the symptoms referred to in question 2 consistent with your current diagnosis? Yes ◯ No ◯

If No, please elaborate: _____

_____

6. Based on the claimant's own reporting, describe the incident that resulted in an injury? _____

_____

_____

7. What symptoms are currently causing the claimant's absence from work? _____

_____

_____

8. Is any other injury or sickness contributing to the disablement? Yes ◯ No ◯ If Yes, please give details: _____

_____

_____

9. Has the claimant been hospitalised for this condition? Yes ◯ No ◯ If Yes, advise dates the claimant was admitted and discharged? _____

_____

10. Has treatment or advice been sought from other medical practitioners? Yes ◯ No ◯

If Yes, advise the details of the consultations:

PRACTITIONER'S NAME	FIRST DATE OF ATTENDANCE	SPECIALTY	PHONE	FAX
GP:	/ /			
	/ /			
	/ /			

11a. Has the claimant ever previously suffered from the same or a related condition? Yes ◯ No ◯ If Yes, advise details of the previous condition and who treated the claimant: _____

_____

_____

11b. If the current incapacity is caused by a re-occurrence of the same condition, was this to be expected or inevitable? Yes ◯ No ◯

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Medical Practitioner's Statement ➲ SECTION E continued

12. Do you consider that the claimant has been (or will be) wholly and continuously prevented from carrying out his or her usual duties? Yes ◯ No ◯

13. If you answered Yes to question 12, please advise a **minimum** period for which the claimant will be or has been disabled. (We appreciate that the disablement may extend beyond the current 'To' date provided.)

From: _____ /_____ /_____ To: _____ /_____ /_____

14. When will the claimant be fit for: **a.** Full duties: _____ /_____ /_____ **b.** Alternative duties: _____ /_____ /_____

15. Is there anything in the claimant's medical history which may delay his/her recovery? Yes ◯ No ◯

If Yes, please provide details and how long recovery may be delayed: _____

_____

_____

16. What is the claimant's treatment/rehabilitation programme? _____

_____

_____

17. What is the claimant's prognosis? _____

_____

_____

_____

18. How long has the claimant been attending your practice? _____

I hereby certify that I have personally examined the above-named claimant and declare that all information provided and supplied herein is true and accurate.

Name: _____ Qualification: _____

Telephone: _____ Fax: _____ Email: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Signed: _____ Date: _____ /_____ /_____

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SECTION F ➔ Employer's Statement (Employer to complete)

Company Name: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Telephone: _____ Fax: _____ Email: _____

1. I hereby confirm that (insert claimant's name) _____ has been unable to attend his or her usual duties as a result of an injury commencing on _____ /_____ /_____
2. The claimant has been totally ◯ / partially ◯ disabled since _____ /_____ /_____
   and is due to return ◯ / did return ◯ to work on _____ /_____ /_____
3. The *average* weekly income excluding all overtime and allowances (before personal deductions and income tax) actually paid to the claimant earned from personal exertion during the 12 month period immediately preceding disablement was $ _____
4. During the period of disablement, the claimant has received from the company:

	TOTAL $	FROM	TO
NORMAL PAY		/ /	/ /
RDOs		/ /	/ /
CURRENT SICK LEAVE		/ /	/ /
CURRENT ANNUAL LEAVE		/ /	/ /
SALARY IN LIEU OF NOTICE		/ /	/ /
UNPAID LEAVE		/ /	/ /
OTHER (PLEASE SPECIFY)		/ /	/ /

If Other, please describe: _____

5. Date the claimant commenced with the company: _____ /_____ /_____
   on a: Full Time ◯ Part Time ◯ Casual ◯ Contractor basis ◯
6. Claimant's current status: Still an employee Yes ◯ No ◯
7. Claimant's job title: _____
8. Claimant's pre-injury work duties: _____
9. Are you prepared to offer the claimant suitable alternative duties? Yes ◯ No ◯
   If Yes, please provide details of those duties: _____

Declaration

I hereby declare that:

a. We are the claimant's current employer (or accountant if the claimant is self employed)

b. After reasonable inquiry, we confirm that the employment and salary details supplied are true and accurate

c. We will supply upon further request any information which may be required for ongoing assessment and determination of this claim.

Name: _____ Position: _____

Signed: _____ Date: _____ /_____ /_____

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