# Personal Accident Claim Form

## Football NSW Risk Protection Program

### Please read this page before completing the claim form

Dear Member,

Thank you for your claim form request. This letter contains important information relevant to your claim. Please read it carefully and make sure you understand its contents.

**We require the claim form to be fully completed and returned within 30 days of your injury.**
**DO NOT wait until treatment is complete before submitting the claim form.**

1. The Physician's Report on page seven (7) must be completed by the main doctor, surgeon or dentist who is providing treatment for your injury.
2. For claims under the Loss of Income Benefit, your employer must complete the Employer's Statement on page six (6). A Return to Work Statement from your employer is also required before processing can be completed. If you are self-employed, the Statement on page six (6) showing income details must be completed by your accountant.
3. Please send all receipts for Non-Medicare medical expenses. If you are claiming from a private health insurer, please send those statements along with your receipts.
4. Insurers will commence working on your claims immediately however, claims cannot be settled (entitlements calculated) until all accounts have been paid and refunds from your private health insurer have been obtained.
5. There are excesses on claims for medical expenses and on claims for loss of earnings. For precise details and information regarding policy maximums and excesses, please contact your club or association or visit www.gowgatessport.com.au/football.
6. Gow-Gates values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement, please visit our website at www.gowgates.com.au

If you have any queries, please call us

immediately. Telephone: 02 8267 9999

Please send all completed claim forms to:
CLAIMS DEPARTMENT
Gow-Gates Insurance Brokers Pty Ltd.
GPO Box 4731, Sydney NSW 2001
football@gowgates.com.au

## How to lodge a Personal Injury Claim:

1. Complete ALL sections of the personal Injury Claim Form
    - Your claim form may be returned if there is important information missing
    - For assistance please contact your Gow-Gates Claims team; toll free 1800 811 371 or 02 8267 9999
    - Send your completed claim form to Gow-Gates Claims Department as outlined on the first page (1).

Please note; email is the most efficient method of claim lodgement

2. Within 30 days from the date of injury
    - Do not wait until your treatments have concluded before you lodge your claim
    - You can lodge your claim even if you have no out of pocket expenses
3. Gow-Gates will confirm receipt of your claim and provide you with a claim number; or contact you should they require further information
4. Once you have received your Claim Number, you can forward further Non-Medicare medical receipts to Gow-Gates as your treatment continues (for up to 12 calendar months from the injury date).

## What should I send with my claim?

Receipts- If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to Gow-Gates.

Retain a copy- Please submit only original receipts to Gow-Gates. We recommend you retain a copy of all receipts and your Claim Form records.

Private Health Insurance (if applicable)- Please claim through your Private Health Fund first and then send Gow-Gates a copy of your Private Health rebate advice.

## Claims Conditions

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to Gow-Gates within 30 days from the date of injury.

- Subject to the policy, any treatment must be completed within 12 calendar months from the date of injury. Physiotherapy, chiropractic and or similar treatment must first be referred by a legally qualified medical practitioner.
- All certifications and evidence required by Gow-Gates must be provided by you upon request and at your expense (if applicable). Back dated medical certificates will not be accepted, and medical certificates from a legally qualified medical practitioner can only be accepted and must be provided at least every four (4) weeks for loss of income benefits.
- Due to government legislation there is no cover available for any medical expense for which a benefit is or can be claimed through Medicare including the balance of monies due or payable by You after the deduction of any Medicare benefit or rebate from the actual medical expense incurred (commonly known as the "Medicare Gap").

### Code of Practice and Privacy Act

Gow-Gates Insurance Brokers Pty Ltd proudly supports the Insurance Brokers Code of Practice, and are committed to raising standards of services to our customers. This voluntary code sets out the minimum standards we will uphold in the services we provide to you.

The Privacy Act sets out how we are able to collect, use, disclose and protect your personal information. It also describes the circumstances for you to access and, if neccessary, correct your personal information. You may access your personal information by contacting our office on 02 8267 9999. The information we collect is used to assist us to provide you with our general insurance products and to manage our relationship with you. If you do not wish to provide us with your personal information, we will not be able to supply our products to you.

Before you commence filling in this form, please make sure you have read and fully understood the dialogue on the front of the claim form as it contains important information relating to your claim. If you have any questions at all about its content or meaning, please contact the Gow-Gates office.

## Section A: Claimant's Details

| | | | |
|---|---|---|---|
| Name of Claimant: | | | |
| Postal Address: | | | |
| Date of Birth: | / / | Sex: | Male ☐ Female ☐ |
| Contact Details: | Phone: | Mobile: | |
| | | Email: | |
| Club Name: | | | |
| Association Name: | | | |

## Injury Data

Date of Injury: / / Time of Injury:

Session: ☐ Playing ☐ Training ☐ Travelling ☐ Event ☐ Warm up/down Other

Location: ☐ Indoor ☐ Outdoor

Injured Person: ☐ Player ☐ Referee ☐ Official ☐ Trainer Other

Grade: Player ☐ Senior ☐ Junior ☐ Not Applicable

Surface Type: ☐ Grass ☐ Synthetic Grass ☐ Indoor ☐ Timber ☐ Asphalt ☐ Concrete

Weather Conditions: ☐ Fine ☐ Rain ☐ Extreme Heat ☐ Extreme Cold Other

Surface Conditions: ☐ Wet ☐ Dry ☐ Muddy ☐ Indoor Other

Half: ☐ 1st ☐ 2nd

Resumption dates(s):

| / / | / / | / / |
|---|---|---|
| When will you resume work? | When will you resume training? | When will you resume playing |

Private Health Cover:

Yes ☐ No ☐

Do you have Private Health Insurance?

If yes, what is the name of your Private Health Insurance Provider _____

Private Health Coverage: ☐ Dental ☐ Physiotherapy ☐ Ambulance ☐ Hospital

Ambulance Membership: ☐ Yes ☐ No

Descibe your injury and how it happened (please attach additional pages if required):

_____

_____

_____

## Payment Details

PLEASE NOTE – For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

Please select how you would like to be reimbursed for this claim?

Mail cheque ☐ Direct bank deposit (Please provide details below) ☐

| | | | |
|---|---|---|---|
| Bank name: | | | |
| Beneficiary name: | | | |
| BSB number: | | Account number: | |

**PLEASE NOTE**

Original receipts and all statements of any benefits received from any source must be sent to Gow-Gates as soon as possible. Failure to do so will result in settlement delays. Please also remember to inform us in writing when your treatment is complete. This will also reduce delays in settlement of your claim.

| | | |
|---|---|---|
| Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)? | ☐ Yes | ☐ No |
| Have you ever made previous claims in respect to a personal accident insurance policy or plan? | ☐ Yes | ☐ No |
| Have you engaged in any other income earning employment since you became injured? | ☐ Yes | ☐ No |

## Section B: Declaration and Authorisation by Injured Person

I hereby authorise any hospital, physician, medical practitioner, medical specialist or any other person who has attended me and / or employer of mine, past or present, to furnish Gow-Gates and / or its representatives with any and all information with respect to any sickness or injury, medical history, consultants, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers including verification or my earnings.

I acknowledge that any personal information that I have or will provide to Gow-Gates is necessary for and will be used in processing, assessing, investigation or review of this claim. I hereby authorise Gow-Gates and / or its representatives and consent to Gow-Gates and / or its representatives and its authorised agent to disclose any personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed / authorised broker, account broker, and / or broker of the entire / body corporate / organisation insured (Insured), 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, I can contact the Gow-Gates office.

I agree that a photocopy / scanned 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.

Name:

Signature:

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for prosecution.

## Section C: Associations & Club Declaration

| | | | |
|---|---|---|---|
| Name of Claimant: | | | |
| Club Name: | | | |
| Club Contact Details: | Phone: | Mobile: | |
| | | Email: | |
| Association Name: | | | |

## Injury Details

| | |
|---|---|
| Date of Injury: | / / Time of Injury: |
| Circumstances: | ☐ Playing ☐ Training ☐ Travelling Other |
| Opposition Club Name (if applicable): | |
| Ground Location (where it occured): | |
| Resumption date(s): | ☐ Yes ☐ No Has the claimant returned to training? / / If yes, date Claimant returned? |
| Is the player registered? | ☐ Yes ☐ No FFA Registration Number |

## Club Declaration

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised Representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).

B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.

C. You declare the Claimant's injury was sustained accidentally during the football activity noted above and is not a pre-existing illness or condition to the best of your knowledge

Club Representative's Name:

Club Representative's Signature:

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for prosecution.

## Association Declaration

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).

B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate to the best of your knowledge.

Association Representative's Name and Title:

Association Representative's Signature:

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for Prosecution

## Section D: Employer's Statement (ONLY complete this section if you are claiming loss of Income Benefits). To be completed by the Claimant's Employer (or accountant if Self-Employed)

| | | | |
|---|---|---|---|
| Claimant's Name: | | | |
| Employer/Business: | | | |
| Occupation: | | | |
| Postal Address: | | | |
| Contact Details: | Phone: | Mobile: | |
| | | Email: | |
| Employment Status: | ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed | | |
| Employment Details: | $ _____ Employee's NET weekly salary<br>$ _____ Employee's GROSS weekly Salary<br>/ / _____ Date employee commenced with the company<br>/ / _____ Date employee ceased work<br>/ / _____ Date expected to resume duties | | |
| Returned to Work: | ☐ Yes ☐ No Has the Employee returned to work?<br>/ / _____ If yes, what date did the Employee return? | | |
| Salary Received: | ☐ Yes ☐ No During the period of incapacity, has the employee received a salary?<br>If yes what for?<br>Sick Leave from / / to / /<br>Annual Leave: from / / to / /<br>Other: from / / to / / | | |

## Employer's Declaration

By signing the declaration below, you confirm and agree to the following:

A. You are the Claimant's current employer (or accountant if the claimant is self-employed).

B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate.

C. You will supply upon request any further information as required for the determination of this claim.

| |
|---|
| Employer's/ Accountant's Name: |
| Employer's/ Accountant's Signature: |
| Date: |

## Section E: Physician's Report

**PLEASE NOTE**

These questions are to be completed by the main doctor, dentist or surgeon not by a physiotherapist or chiropractor. The insured is responsible for the completion of this form and any charges incurred for its completion.

| Patients (Claimant's) details: | |
|---|---|
| Name: | |
| Physician's Details: | |
| Physician's Telephone: | |
| Physician's Email: | |
| Diagnosis/History of Injury: | |
| Injury Location: | ☐ Ankle ☐ Arm ☐ Dental ☐ Facial ☐ Foot<br>☐ Hand ☐ Head ☐ Internal ☐ Knee ☐ Lower Leg<br>☐ Shoulder ☐ Spinal ☐ Torso ☐ Upper Leg |
| Injury Type: | ☐ Amputation ☐ Bruising ☐ Concussion ☐ Cut<br>☐ Dental ☐ Dislocation ☐ Fracture/Break ☐ Rupture<br>☐ Strain ☐ Fatigue/Debilitation ☐ Sprain ☐ Death |
| First Medical Treatment: | / / _____ Date of treatment<br>_____ Name of attending physician |
| Do you consider the Claimant's injury to be a NEW injury? | ☐ Yes ☐ No |
| Do you consider the Claimant's injury to be a recurrence of a previous injury? | ☐ Yes ☐ No |
| If YES, please provide details and a description: | |

## Section E: Physician's Report CONTINUED

| Patient's (Claimant's) details CONTINUED | |
|---|---|
| Does the Claimant have any congenital defects or chronic diseases? | ☐ Yes ☐ No |
| If YES, please provide details and a description: | |
| Have you referred the patient to any other services or treatment? | ☐ Yes ☐ No |
| If YES, please provide details below: | Physiotherapy: ☐ Yes ☐ No<br>If yes, approx number of treatments required<br>Chiropractics: ☐ Yes ☐ No<br>If yes, approx number of treatments required<br>Surgery: ☐ Yes ☐ No<br>If yes, approx number of treatments required<br>Other: ☐ Yes ☐ No<br>If yes, please provide details |
| Has the Claimant been able to do any work since the injury occured? | ☐ Yes ☐ No |

## Physician's Declaration

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form.

B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Name:

Physician's Signature:

Date:

## Loss of Income claims only

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

## Incapacity to work statement

I, _____ examined _____ on _____

In my opinion, this person is/has been unfit to work from _____ to _____ inclusive

First day of incapacity — Last day of incapacity

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form.

B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Name:

Physician's Signature:

Date: