DUAL Sports Personal Accident

Claim Form: Amateur

The issue of this form is not an admission of liability

Please Ensure

- You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.
- ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition" cannot be accepted)

Section 1 - Claimant Details

Club Name: Member No:

Claimants Name:

Event or other Activity:

Name of team / age group / grade:

Gender (please tick): Male ☐ Female ☐ Date of Birth:

Occupation:

Address:

Email:

Phone: Work: Home: Mobile:

Please tick the category applicable: ☐ Player ☐ Official ☐ Member ☐ Volunteer

☐ Other, please specify:

To be completed by the claimant

Section 2 - Accident Details

Describe how the accident happened:

Describe your injury:

Did the injury cause you to stop work? Yes ☐ No ☐

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

What 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 ☐

Please provide the address of where the injury occurred?

State: Postcode:

State the name of any one witness to the injury:

Address of Witness:

Person to whom accident/incident was 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? Yes ☐ No ☐

If yes, please advise the name of the hospital:

If admitted into hospital, how long were you there?

Name of person who gave treatment?

Advise below when you did (or expect to):

Cease work/normal activities: Cease training:

Resume work/normal activities: Resume training:

Cease participating: Resume participating:

Have you ever had this injury or similar injuries in the past? Yes ☐ No ☐

If yes, please advise when? Date:

Provide details:

Only complete this section if claiming for these expenses

Section 3 - Non Medicare Medical 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:

Do you have Hospital Cover? Yes ☐ No ☐

Are you covered for Extras incl. Physio etc Yes ☐ No ☐

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

Name of Provider	Nature of Service (eg Dental, Physio etc.)	Date of Service	Charge	Private Health Fund Recovery (if applicable)	Amount Claimable

Only complete this section if you are claiming for loss of income

Section 4 - Loss of income

1. Can compensation be claimed under worker's compensation or any other insurance including Loss of Income? Yes ☐ No ☐

2. Have you ever made any previous claims in respect to personal accident insurance or any other similar insurance? Yes ☐ No ☐

3. Have you engaged in any other income earning employment since you have been injured? Yes ☐ No ☐

The following section must be completed by your employer/salary officer. If self employed, please have your accountant complete these details.

Name of employer:

Address:

Phone:

Date ceased work due to injury: Date expected to resume normal duties:

Employee weekly salary as at date of injury: Average Gross Base Salary $ per week

Base salary, exclusive of overtime, allowances, bonuses and commissions 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 From to

If 'other' please specify

Has the employee returned to work? Yes ☐ No ☐

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

If Employed

Salary Officers Name:

Phone:

Email:

Salary Officers Signature: Company Stamp:

Date:

ABN / ACN:

If Self Employed

Accountant's Name:

Phone:

Section 5 - 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 (Physiotherapist may complete for minor injuries only).
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

Patient's Full Name:

How long have you known the patient? Date of Birth:

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

On what date was medical treatment first sought?

With whom?

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? (Please detail symptoms and diagnosis and how Injury was sustained)

Do you consider the patients 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:

Has the patient ever suffered this or a similar condition before? 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 ☐ Date: No ☐

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

Some Duties: Full Duties:

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:

Section 6 - 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:

Phone:

Email:

Address:

Signature: Qualifications:

Date:

Section 7 - Method of Payment

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account.

Section 8 - Bank Account Details

Please complete the following:

Bank:

Account Name(s):

BSB Number:

Account Number:

Declaration

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim. I authorise any hospital, physician or other person who has attended me to furnish the claims manager Corporate Services Network (CSN) or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Insured(s)

Position:

Signature:

Date:

Section 10 - Claim Lodgement Details

Please forward claim details using one of the following lodgement processes

(Please keep a copy of all documents sent to Corporate Services Network (CSN))

Postal Address:
Corporate Services Network (CSN)
GPO Box 4276
Sydney NSW 2001

Email Address:
claims@csnet.com.au

Fax No:

+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:

+61 (2) 8256 1770

Policy and coverage queries should first be directed to your Insurance Broker.

Section 11 - Privacy Statement

At DUAL Australia Pty Ltd, we are committed to compliance with the Privacy Act 1988 (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services.

We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2) contracted third party providers who supply us with services such as claims investigation and management companies, legal and medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains information about how you can access the information we hold about you, ask us to correct it, or make a privacy related complaint. You can obtain a copy from our Privacy Officer by telephone (+61 (0)2 9248 6300), email (reception@dualaustralia.com.au) or by visiting our website (dualinsurance.com).

By signing this claim form, you consent to the collection and use of your personal information as outlined above and in our Privacy Policy.

Section 12 - Declaration by Association

Name of Association / Club:

Name of Official making this statement:

Official's Position: Phone:

Email:

Address:

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

If yes, please specify:

I, the above mentioned Club Official, confirm that the claimant was a registered and Financial member of this club 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.

Signature of Association / Club Official:

Dated: