JLT SPORT PERSONAL INJURY CLAIM FORM

AUSTRALIAN FOOTBALL NATIONAL RISK PROTECTION PROGRAMME

IMPORTANT INFORMATION

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- You are an Insured person – player, umpire, official or volunteer; and
- You have sustained an injury – whilst participating in a sanctioned cricket activity/event; and
- You have incurred costs – Non-Medicare medical costs

Before completing this form, please read the Product Disclosure Statement (PDS) on our website www.jltsport.com.au

WHAT IS COVERED?

Non-Medicare Medical Costs
Death & other Capital Benefits
Loss of Income cover is available as an optional extra that can be purchased for additional premium.

HOW MUCH CAN I CLAIM?

The following table outlines the various levels of cover within this Programme.

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursement	75% Reimbursement	90% Reimbursement	90% Reimbursement
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim

- All clubs receive, at least, the Bronze level of cover at the start of each period of cover.
- Clubs/Leagues may choose to upgrade to a higher level of cover for an additional premium.
- Upgraded cover is valid only from the date of purchase.
- If you do not know what level you have, please contact your club and/or league for details.

HOW TO LODGE A PERSONAL INJURY CLAIM

1. Complete ALL sections of this form
2. Send your completed form to Echelon as soon as possible (and within 270 days from the injury date)
3. Echelon will confirm receipt of your claim and provide you with a claim number
4. Any further costs can be submitted to Echelon quoting this claim number
5. Documents can be submitted by email, post or fax

HOW TO SEND COMPLETED FORMS

Email:	sportsclaims@echelonaustralia.com.au
Post:	Echelon Claims Services - GPO Box 1693 Adelaide SA 5001
Fax:	08 8235 6107

IMPORTANT INFORMATION

You can't claim for any services where you receive a rebate from Medicare
Submit only original receipts with your claim form
We recommend you retain a copy of all receipts and your claim form for your records
Claim through your Private Health Fund first, where possible.

SECTION A - CLAIMANTS DETAILS								
Claimant's Name:								
Postal Address:								
Occupation:								
Email Address:				Phone Number:				
Date of Birth:						☐ MALE	☐ FEMALE	
Date of Injury:		Time Of Injury:				☐ AM	☐ PM	
Club Name:								
League Name:								
Describe your injury and how it happened (please attached additional pages if required):								

INJURY RESEARCH DATA								
Session:	☐ Playing		☐ Training		☐ Travelling			
	☐ Event		☐ Warm up/down		☐ Other			
Injured Person:	☐ Player	☐ Umpire	☐ Official	☐ Trainer	☐ Other			
Grade:	☐ Senior	☐ Reserve	☐ Junior	☐ Not Applicable				
Surface Conditions:	☐ Wet		☐ Dry		☐ Muddy			
	☐ Indoor		☐ Other					
Period:	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ Not Applicable			
When will you resume WORK?								
When will you resume TRAINING?								
When will you resume PLAYING?								
Do you have Private Health Insurance?						☐ YES	☐ NO	
If YES, what is the name of your Private Health Insurance Provider?								
Private Health Coverage:	☐ Dental	☐ Hospital	☐ Ambulance	☐ Physiotherapy				
Ambulance Membership?						☐ YES	☐ NO	
Bank:			Account Name:					
BSB:			Account Number:					

CLAIMANT DECLARATION

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

1. The injury was sustained accidentally during a football activity and is not a pre-existing illness or condition.
2. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/afl
3. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).
4. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, the Trustee and the Claims Managers.
5. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish JLT's representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.
6. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.
7. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.
8. You authorise any and all information regarding claims with any other insurer to be released to JLT's representatives.

Claimant's Signature: *(Parent or Guardian if under 18 years)*		Date:	

SECTION B - CLUB DETAILS					
Claimant's Full Name:					
Club Name:					
Club Contact:					
Position within Club:					
Email Address:		Phone Number:			
League Name:					
Registration Details:					
Non-Medicare Cover: (If Known)					
Loss of Income Cover: (If Known)					

INJURY DETAILS					
Date of Injury:		Time of Injury:		☐ AM	☐ PM
Circumstances:	☐ Playing	☐ Training	☐ Travelling	☐ Other (Please specify)	
Opposition Club Name: (If Applicable)					
Ground/Location Where the Injury Occurred:					
Has the Claimant returned to TRAINING?				☐ YES	☐ NO
If YES, date Claimant returned?					
Has the Claimant returned to COMPETITION?				☐ YES	☐ NO
If YES, date Claimant returned?					

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 League (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.
D. You understand that registering your club with JLT Sport is a requirement of the AFL National Risk Protection Programme for each Period of Cover.
E. You confirm the club's level of cover as per the details provided above.

Club Representative's Signature:		Date:	

SECTION C – LOSS OF INCOME (TO BE COMPLETED BY THE CLAIMANT)

Do you wish to claim Loss of Income Benefits?	☐ YES	☐ NO

IF YOU ARE NOT CLAIMING LOSS OF INCOME BENEFITS PLEASE DO NOT COMPLETE THIS SECTION. PLEASE PROCEED TO SECTION D

The elimination period is a period of consecutive days during which no benefits are payable. The elimination period under the insurance policy for loss of income benefits is 14 days or your sick leave entitlement as an employee whichever is greater.

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

TO BE COMPLETED BY THE CLAIMANTS EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)

Claimants Name:						
Employer/Business:						
Contact Person:						
Postal Address:						
Email Address:						
Phone (Bus. Hours):					Mobile:	
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual		☐ Self Employed	
Employment Details If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.						
Employee's NET weekly salary:					$	
Employee's GROSS week salary:					$	
Date Employee commenced with company:						
Injury Details:						
Date employee ceased work:						
Date expected to resume duties:						
Returned to Work:						
Has the Employee returned to work?					☐ YES	☐ NO
If YES, what date did the Employee return?						
Salary Received:					$	
During the period of incapacity, has the employee received a salary?					☐ YES	☐ NO
If YES, what for?						
Sick Leave:	☐ YES	☐ NO	From:		To:	
Annual Leave:	☐ YES	☐ NO	From:		To:	
Other:	☐ YES	☐ NO	From:		To:	

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived from playing sport.

EMPLOYERS 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 Signature: * Accountant's signature (if claimant is self-employed)		Date:	

SECTION D - PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT - This section must be completed (in full) by your attending physician. *An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.*

Claimant's First Name:		Claimant's Last Name:	
Physician's Name:		Phone Number:	

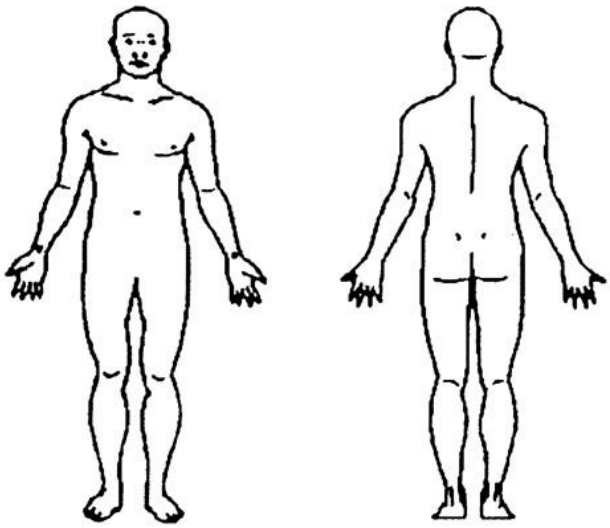
INJURY CONSULTATION

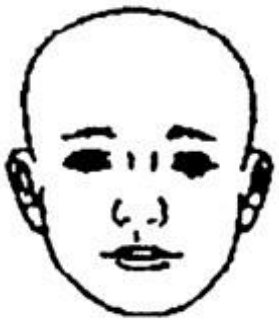
Date of Injury:		Date of Consultation:	

Diagnosis/History of injury:

Injury Location:	☐ Ankle	☐ Arm	☐ Dental	☐ Facial	☐ Foot
	☐ Hand	☐ Head	☐ Internal	☐ Knee	☐ Lower Leg
	☐ Shoulder	☐ Spinal	☐ Torso	☐ Upper Leg	

Please mark (**X**) the anatomical location below:





Injury Type:	☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut	☐ Death
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Rupture	☐ Sprain
	☐ Strain	☐ Fatigue/Debilitation			

First Medical Treatment:			
Name of attending physician:			
Date of treatment:			
Do you consider the Claimant's injury to be a NEW injury?		☐ YES	☐ NO
Do you consider the Claimant's injury to a recurrence of a previous injury?		☐ YES	☐ NO

INJURY CONSULTATION CONTINUED		
If YES, please provide details and a description:		
Does the Claimant have any congenital defects or chronic diseases?	☐ YES	☐ NO
If YES, please provide details and a description (dates, name of treating doctor, etc):		
Have you referred the patient to any other services or treatment?	☐ YES	☐ NO
If YES, please provide details below:		
Physiotherapy:	☐ YES	☐ NO
If YES, approx. number of treatments required.		
Chiropractic's:	☐ YES	☐ NO
If YES, approx. number of treatments required.		
Surgery:	☐ YES	☐ NO
If YES, please provide details		
Other:	☐ YES	☐ NO
If YES, please provide details		
Has the Claimant been able to do any work since the injury occurred?	☐ YES	☐ NO
What date do you advise the Claimant to return to playing Football?		

MEDICAL PRACTITIONER'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.			
Medical Practitioner'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 _____

(Medical Practitioner's Name) (Claimant's Name) (Date of Examination)

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

(First day of Incapacity) (Last day of Incapacity)

Please provide any further comments in regard to your assessment of the injury/condition:

For more information, please refer to JLT Sport's web site www.jltsport.com.au/afl

JLT COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) draw your attention to the following:

We may collect personal information about you by means of the enclosed document.

We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other JLT products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.

The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and JLT related Group companies.

Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other JLT Group companies, insurers, reinsurers and other third party service providers (e.g. data storage providers) in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.

If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent. We will use and disclose your personal information in accordance with our Privacy Policy.

Our Privacy Policy can be accessed on our website (http://au.jlt.com/). For further information contact your account executive or the JLT Privacy Officer:

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