JLT SPORT PERSONAL INJURY CLAIM FORM

Hockey Australia National Risk Protection Programme

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- ✓ Insured - You are a participant, official or volunteer (Insured Person) of a Club/Association (the Insured) covered within the Hockey Australia National Risk Protection Programme; and
- ✓ Injured - You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned hockey-related event/activity on or after 31/12/2017; and
- ✓ Non-Medicare/Loss of Income - You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme and/or have incurred time off work due to your injury.

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on JLT Sport's website www.jltsport.com.au/hockey

WHAT IS COVERED?

The Hockey Australia National Risk Protection Programme's Personal Injury cover provides some reimbursement for Non-Medicare Medical costs and/or Loss of Income cover for 12 months from the date of injury.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Medicare Gap. Non-Medicare Medical Benefits are covered up to the limits outlined below.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS).

WHAT ARE MY LEVELS OF COVER?

The following table outlines the reimbursement capacity for the cover within the Hockey Australia National Risk Protection Programme.

Non-Medicare Medical Costs	**Loss of Income**
75% Reimbursement	80% Reimbursement of Gross Weekly Wage
$3,500 maximum per claim	Up to a maximum of $350 per week
$50 excess per claim	14 day elimination period/52 week benefit period

All clubs receive the above coverage at the commencement of each period of cover.
Upgraded cover is available (please visit our website).

WHAT IS NOT COVERED

The following examples demonstrate some areas not covered by the Personal Injury cover:

- Medicare items (see below);
- The Medicare Gap (see below);
- Injuries sustained whilst playing against medical advice.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS) for further details.

WHAT DOES NON-MEDICARE MEAN?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the "Medicare Gap".

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer or the JLT Trustee to reimburse any part of a Medicare Item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Hockey Australia National Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or www.medicare.gov.au

Please note: some Private Health Funds may offer Medicare Gap Insurance Cover. JLT Sport is not a Private Health Fund, nor do we offer Private Health Insurance.

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 Sports Underwriting Australia(SUA) on 1300 761 195.
2. Send your completed claim form to SUA Claims Department – austclaims@aig.com or GPO Box 4363, Melbourne, VIC 3001 within 180 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. SUA 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 SUA as your treatment continues (for up to 12 months from the date of injury).

WHAT SHOULD I SEND WITH MY CLAIM?

1. Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to SUA.
2. Retain a copy - Please submit only original receipts to SUA. We recommend you retain a copy of all receipts and your Claim Form for your records.
3. Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send SUA a copy of your Private Health rebate advice.

CLAIM CONDITIONS

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to SUA within 180 days from the date of injury.

Subject to the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by SUA must be provided by you upon request and at your expense (if applicable).

WHO IS JLT SPORT

JLT Sport is the appointed broker for the Hockey Australia National Risk Protection Programme. As a division of Jardine Lloyd Thompson Pty Ltd, JLT Sport is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries.

SECTION A – CLAIMANT'S DETAILS

PERSONAL INFORMATION

Claimant's Name:					
Address:					
State:		Postcode:			
Occupation:					
Phone Number:					
Email Address:					
Date of Birth:		Gender:		☐ Male	☐ Female
Date of Injury:		Time of Injury:		☐ AM	☐ PM
Club Name:					

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

INJURY RESEARCH DATA

When did the injury occur	☐ WARM UP	☐ WARM DOWN	☐ TRAINING/LESSON
	☐ COMPETITION	☐ OTHER	
Level of involvement?	☐ CLUB	☐ STATE	☐ NATIONAL
	☐ OTHER		
Injured Person	☐ PLAYER	☐ COACH	☐ UMPIRE
	☐ CLUB VOLUNTEER	☐ OTHER	
How did the injury occur?	☐ FALL/TRIP	☐ RUNNING	☐ HIT BY STICK
	☐ OVERUSE	☐ OTHER	

Resumption date(s):

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	☐ PHYSIOTHERAPY	☐ AMBULANCE	☐ HOSPITAL	
Ambulance Membership:				☐ YES	☐ NO

PAYMENT DETAILS			
To whom should we make payment?		☐ MYSELF	☐ OTHER
Payee Name/Account Name			
How would you like to receive payment?		☐ EFT	☐ CHEQUE
Payee Postal Address:			
Bank:			
BSB:		Account Number:	

CLAIMANT DECLARATION	
By signing the declaration below, you confirm and agree to the following: A. The injury was sustained accidentally during a hockey activity and is not a pre-existing illness or condition. B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/hockey. C. 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). D. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, and the Claims Managers. E. You authorise any hospital, physician, Private Health and/or Income Protection insurers, 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. F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original. G. 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. H. 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 DECLARATION

CLUB DETAILS	
Claimant's Name:	
Club Name:	
Name of Club Contact:	
Position within Club:	
Phone Number:	
Email Address:	
Association Name:	

CLUB DETAILS CONTNUED					
Registration Details:					
Is the Club Registered for this Period of Cover?				☐ YES	☐ NO
INJURY DETAILS					
Date of Injury:		Time of Injury:		☐ AM	☐ PM
When did the injury occur	☐ PLAYING	☐ TRAINING	☐ TRAVELLING		
	☐ OTHER				
Opposition Club Name: (if applicable)					
Ground/Location:					
Resumption date(s):					
Has the Claimant returned to RESTRICTED TRAINING?				☐ YES	☐ NO
If YES, date Claimant returned?					
Has the Claimant returned to FULL 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 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 hockey 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 National Hockey 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? **If No, please proceed to SECTION D**	☐ YES	☐ NO
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
Claimant's Name:		
Employer/Company Name:		

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED) CONTINUED						
Contact Person:						
Postal Address:						
State:			Postcode:			
Email Address:						
Phone: (Bus. Hours)			Mobile:			
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual		☐ Self Employed	
Employment Details:						
Employee's NET weekly salary					$	
Employee's GROSS week salary					$	
Date Employee commenced with company.						
IF SELF-EMPLOYED OR CASUAL, PLEASE PROVIDE AVERAGE WEEKLY SALARY BASED ON 12 MONTH PERIOD DIRECTLY PRIOR TO INJURY.						
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.						

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

EMPLOYER'S DECLARATION CONTINUED

For more information, please refer to JLT Sport's web site:

https://hockey.jltsport.com.au

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

SECTION D – PHYSICIAN'S REPORT

PHYSICIAN'S REPORT

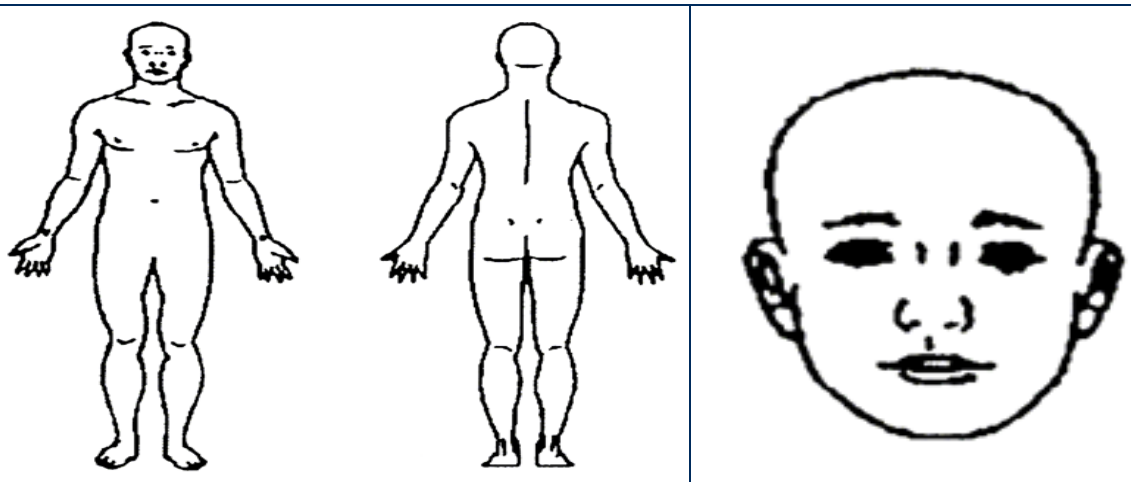
This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT/SUA

Claimant's Name:			
Physician's Name:			
Phone Number:			
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 (×) the anatomical location below:



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

PHYSICIAN'S REPORT CONTINUED		
FIRST MEDICAL TREATMENT		
Date of treatment:		
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 a recurrence of a previous injury?	☐ YES	☐ NO
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:	☐ 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 Hockey?		

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 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 _____ inclusive.

First day of incapacity | Last day of incapacity

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

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:	

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 (www.au.jlt.com). For further information contact your account executive or the JLT Privacy Officer:

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