Personal Injury Claim Form Indoor Cricket Queensland Risk Protection Program

IMPORTANT INFORMATION: LETTER TO CLAIMANT

IMPORTANT NOTE

Each indoor sports centre has varying levels of coverage.

Please contact your centre to confirm the level of cover before submitting this claim form.

Your centre may not have all of the components detailed below.

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $100,000, under the age of 18 is limited to $20,000 with a $250,000 maximum for Quadriplegia/Paraplegia

Non Medicare Medical Expense

Reimbursement of Non-Medicare medical expenses. Claimable expenses include physiotherapy, private hospital, ambulance, dental etc. A proportion of the private health insurance gap may be refunded. Cover is limited to expenses incurred within 12 months from the date of injury.

Home Tutorial Benefit

Reimbursement of up to 100% of parent's costs relating to tutoring to assist full time students. The benefit period is 52 weeks.

Domestic Help Benefit

Reimbursement of costs associated with cooking, ironing, washing, cleaning and child minding (as insured by the policy) as a result of injury.

Loss of Income

Coverage for lost earnings as a result of injury. The benefit period is 52 weeks and the excess is 14 days.

This insurance cover is underwritten by:-

Lloyds of London through Sportscover Australia Pty Ltd ABN 43 006 637 903

271-273 Wellington Road,

Mulgrave, VIC 3170

1. This information is only a summary of the cover provided. The policies with full conditions are available by contacting Marsh.
2. This insurance program commenced on 1st November 2021 and expires on 1st November 2022.
3. Marsh has arranged this insurance program to provide benefits to those registered members of Indoor Cricket Queensland who, through injury or accident, incur financial loss and who would otherwise not have received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
4. Indoor Cricket Queensland is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

Dear Indoor Cricket Queensland member,

Please find following a claim form. Before lodging this form, please ensure all sections are fully completed. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.
2. Please ensure that you fully complete pages 3 & 4 and sign and date the Declaration.
3. Please ensure that your Centre official completes and signs the Centre Declaration on page 5.
4. For claims involving Loss of Income:-
   a) You must complete page 6 and have your employer/salary officer to complete page 6. If self employed, you must have your accountant complete these details;
   b) Have your Attending Physician complete the page titled "Physician's Report" on page 7 and 8.
5. For claims involving Non-Medicare medical expenses:
   a) Medical treatment must be certified necessary by an attending physician and incurred within Australia (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).
   b) Have your Attending Physician complete the "Attending Physician" statement on page 7 and 8.
6. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

7. Once you have fully completed all sections of the claim form, please forward with receipts and any related documentation to Sportscover Australia Pty Ltd, Locked Bag 6003, Wheelers Hill, VIC 3150.

   Please note it is a good idea to keep a copy of all documents forwarded in regards to your claim and all claims must be submitted to Sportscover Australia within 180 days from the date of injury.
8. Your reimbursement cheque or EFT will be sent to you directly by Sportscover Australia Pty Ltd.
9. Once your claim is registered, you can submit ongoing invoices via Sportscover Australia Pty Ltd –

   Locked Bag 6003, Wheelers Hill, VIC 3150.

   Sportscover Australia Pty Ltd can also be reached on 1300 134 956 should you wish to make enquiries relating to the progress of your claim.
10. If you have any further queries relating to your claim, please do not hesitate to call the Marsh Team on 1300 130 373.

How do I lodge my 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 Sportscover Australia on 1300 134 956.
2. Send your completed claim form to Sportscover Australia Pty Ltd, Locked Bag 6003, Wheelers Hill, VIC 3150 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. Sportscover Australia Pty Ltd 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 Sportscover as your treatment continues (for up to 12 months from the date of injury).

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 Sportscover.

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

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send Sportscover Australia 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 Sportscover 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 Sportscover must be provided by you upon request and at your expense (if applicable).

Who is Marsh Advantage Insurance?

Marsh Advantage Insurance Pty Ltd (ABN 31 081 358 303), Australian Financial Services Licence (AFSL) No 238369 (Marsh Advantage Insurance) will be providing the financial services on your behalf. Marsh Advantage Insurance is a subsidiary of Marsh Inc. Marsh Inc. is a world leader in delivering risk and insurance services and solutions to clients.

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SECTION A: CLAIMANT'S DETAILS

PERSONAL INFORMATION:

Claimant's Name:	First name	Surname	
Postal Address:	Street Address	State	Postcode
Contact Details:	Email Address	Contact Number (Mobile Preferable)	
Personal Details:	/ / Date of Birth	☐ Male ☐ Female Gender	/ / Date of Injury — AM / PM Time of Injury
Occupation:		Team/Club Name:	
Sport played at time of injury:		Centre Name:	

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

INJURY RESEARCH DATA:

When did the injury occur?	☐ Warm Up	☐ Warm Down	☐ Training/Lesson	☐ Competition/Event	☐ Other_____
Type of involvement?	☐ Recreational	☐ State levels	☐ National levels	☐ Elite/international	
Injured Person?	☐ Athlete/ Participant	☐ Coach	☐ Judge	☐ Official	☐ Other_____
How did the injury occur?	☐ Fall	☐ Slip/Trip	☐ Collision	☐ Slip/Trip	☐ Overbalance
Surface Conditions:	☐ Wet	☐ Dry	☐ Muddy	☐ Indoor	☐ Other
What were you attempting to do at the time of injury?		☐ New skill or activity	☐ Pre-learnt skill or activity	☐ General activity	☐ Other
Resumption date(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			

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PAYMENT DETAILS:	
Payee details:	☐ Myself ☐ Other _____ To whom should we make payment? Payee Name
If compensation by cheque:	Payee Postal Address
If compensation by EFTPOS:	Bank Name on Account 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 Indoor Sports activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.au.marsh.com/sport.html

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the 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 Marsh, the insurer, and the Claims Managers.

E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish Marsh'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 Marsh's representatives

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

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SECTION B: CENTRE DECLARATION

CLUB DETAILS:

Claimant's Name:	First name	Surname	
Centre Name:			
Centre Contact:	Centre Contact Person	Position within Centre	
Contact Details:	Contact Phone Number	Email Address	
Affiliation Confirmation:	☐ Yes ☐ No Is the Centre Affiliated with Indoor Cricket Queensland?		

INJURY DETAILS

Date/Time:	/ / Date of Injury	AM/PM Time of Injury		
Circumstances:	☐ Playing	☐ Training	☐ Travelling	☐ Other
Opposition Team Name	If applicable			
Location:	Where did the injury occur?			
Resumption date(s):	☐ Yes ☐ No Has the Claimant returned to TRAINING?	/ / If YES, date Claimant returned?		
	☐ Yes ☐ No Has the Claimant returned to COMPETITION?	/ / If YES, date Claimant returned?		

CENTRE 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 Centre (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 activity noted above and is not a pre-existing illness or condition.

D. The Claimant was a registered and financial member of this Indoor Cricket Queensland centre at the time of injury, and was entitled to insurance cover at the time of injury.

E. You confirm the centre's level of cover as per the details provided above.

Centre Representative's Name:			
Position at Centre:			
Centre Representative's Signature:		Date:	/ /

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WITNESS STATEMENT:			
A Statement from anyone who has witnessed your accident is required. Please have a witness provide a full description of the incident giving rise to the claimant's injury, as seen by the witness:			
Witness's Name:			
Witness's Address:			
Official's Signature:		Date	/ /

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SECTION C: LOSS OF INCOME

TO BE COMPLETED BY THE CLAIMANT:

Do you wish to claim Loss of Income Benefits? If NO, proceed to SECTION D	☐ Yes	☐ No
If you are NOT claiming Loss of Income Benefits please do not complete this section. Please proceed to Section D. If you wish to claim Loss of Income Benefits, ensure your club has purchased Loss of Income Cover for this Period of Cover. Please obtain details of your club's Loss of Income Cover before completing the following questions.		
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 CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):

Claimant's Name:	First name		Surname				
Employer/Business:	Employer/Company Name		Contact Person				
Postal Address:	Street Address		State		Postcode		
Contact Details:	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:	☐ Yes ☐ No Has the Employee returned to work?		/ / If YES, what date did the Employee return?				
Salary Received:	☐ Yes ☐ No During the period of incapacity, has the employee received a salary?	If YES, what for?					
Sick Leave:	☐ Yes ☐ No	Amount Paid:	$	From		To	
Annual Leave:	☐ Yes ☐ No	Amount Paid:	$	From		To	
Other	☐ Yes ☐ No	Amount Paid:	$	From		To	
	Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances.Excludes income derived from playing sport.						

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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:	/ /

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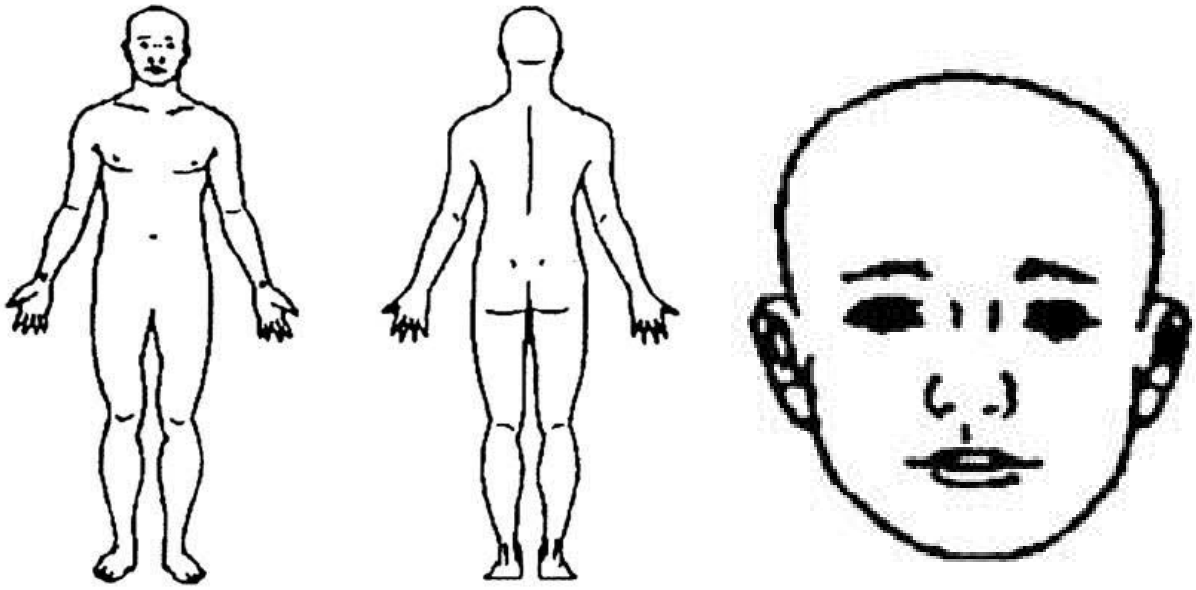
SECTION D: PHYSICIAN'S REPORT

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 MARSH

Claimant's Name:	First name		Surname		
Physician's Details:	Physician's Name		Phone Number		
Injury Consultation:	/ / Date of Injury		/ / Date of Consultation		
Diagnosis/History of injury:					
Physician's Details:	☐ 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:	/ / Date of treatment	Name of attending physician			
Do you consider the Claimant's injury to be a NEW injury?				☐ Yes	☐ No

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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 deases?	☐ Yes	☐ No
If YES, please provide details and a description (dates, name of treating doctor, etc):		

PHYSICIAN'S REPORT

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.
Chiropractics:	☐ 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 sport?	/ /	
If YES, please provide details		

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.

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INCAPACITY TO WORK STATEMENT:

I _____ (Medical Practitioner's Name) examined _____ (Claimant Name) on / / (Date of examination)

In my opinion, this person is/has been unfit to work from / / (First day of incapacity) to / / (Last day of incapacity) inclusive

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	/ /

For more information, please refer to our web site: www.au.marsh.com/sport

MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Marsh Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Marsh') 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 Marsh 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 (Cth), the Marine Insurance Act 1909 (Cth) 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 Marsh's Associated Entities, which are all businesses of Marsh & McLennan group of companies ('MMC').
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other MMC 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, you must obtain it with the individual's consent.
- We will use and disclose your personal information in accordance with our Privacy Policy. By completing this form you confirm that you have read the Marsh Privacy Policy available on our website (www.marsh.com.au) and you authorise and consent to Marsh collecting, holding, using and disclosing any personal information collected by means of the enclosed document in accordance with the terms of the Marsh Privacy Policy, including for the purposes explained in this collection statement above. If there are any inconsistencies between the terms of this collection statement and the terms of the Marsh Privacy Policy, the terms of the Marsh Privacy Policy prevail to the extent of that inconsistency. You may modify or withdraw your consent at any time. If you do not give us consent or subsequently modify or withdraw your consent, we may not be able to provide you with the products or services you want.
- You can contact our Privacy Officer by:

  Email – privacy.australia@marsh.com

  Phone – (02) 8864 7688

  Post – PO Box H176, Australia Square NSW 1215