# Personal Accident Cover Claim Form – AFL 9s

## WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- ✓ You are a member – player, umpire, official or volunteer; and
- ✓ You have sustained an injury – whilst participating in a sanctioned AFL 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.au.marsh.com/sport.html

## WHAT IS COVERED?

Non-Medicare Medical Costs

Loss of Income

Death & other Capital Benefits

Commonwealth Legislation prevents reimbursement of Medicare costs including the Gap.

## HOW MUCH CAN I CLAIM?

| **Non-Medicare Medical Costs** | **Loss of Income** |
|---|---|
| 80% Reimbursement | 80% Reimbursement of weekly income |
| $2,000 maximum per claim | $300 maximum weekly week |
| $100 excess per claim | 14 day elimination period |
| | 52 weeks maximum benefit period |

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

## HOW TO LODGE A PERSONAL ACCIDENT COVER 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

## 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

Marsh

## 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

| | | | | | |
|---|---|---|---|---|---|
| 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: | ☐ First | ☐ Second | ☐ Third | ☐ Fourth | ☐ 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 |

Marsh

| PAYMENT DETAILS | | | |
|---|---|---|---|
| EFT Payee Details: | | | |
| Bank: | | Name Account Held In: | |
| 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 football 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 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, the Trustee and the Claims Managers.

E. 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.

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/product issuer to be released to JLT's representatives.

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

Marsh

## SECTION B – CLUB DECLARATION

### CLUB DETAILS

| | |
|---|---|
| Name of Club Contact: | |
| Position within Club: | |
| Phone Number: | |
| Email Address: | |
| Association Name: | |

**REGISTRATION DETAILS**

| | | |
|---|---|---|
| Is the Club Registered for this Period of Cover? | ☐ Yes | ☐ No |
| Loss of Income Cover: | ☐ Yes | ☐ No |
| Per week | $ | |
| If known, Has the Club purchased additional Loss of Income cover? (above the $500 per week provided within the Program) | ☐ Yes | ☐ No |
| If YES, what is the weekly limit purchased by the Club (if known)? | $ | |

### INJURY DETAILS

| | | | | | |
|---|---|---|---|---|---|
| Date of Injury: | | Time of Injury: | | ☐ AM | ☐ PM |
| Opposition Club Name: (if applicable) | | | | | |
| Ground/Location: | | | | | |

**RESUMPTION DATE(S)**

| | | |
|---|---|---|
| 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 Marsh Sport is a requirement of the AFL National Risk Protection Program 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: | |

Marsh

| SECTION C – LOSS OF INCOME<br>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/cover 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/cover 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: | | | | |
| Employer/Company Name: | | | | |
| 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? | | |

Marsh

| **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:<br>A. You are the Claimant's current employer (or accountant if the claimant is self-employed),<br>B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,<br>C. You will supply upon request any further information as required for the determination of this claim. | |
| Employer's Signature:<br>* *Accountant's signature (if claimant is self-employed)* | |
| Date: | |

**For more information, please refer to Marsh's web site: www.au.marsh.com/sport.html**
**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/JLT**

Marsh

## SECTION D – PHYSICIAN'S REPORT

### PHYSICIAN'S REPORT

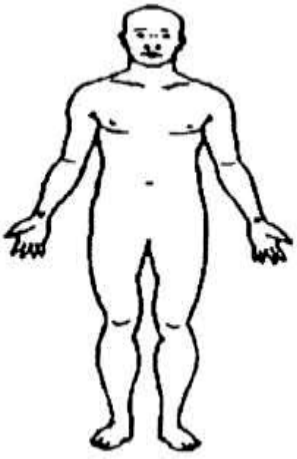
**This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.**

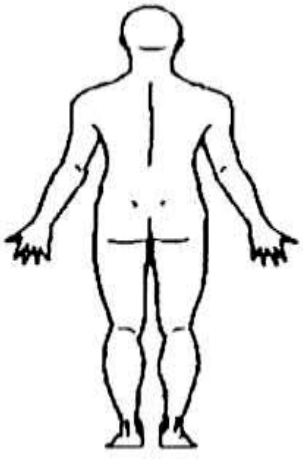
**THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH/JLT**

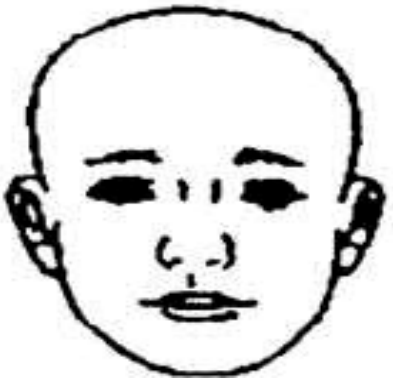
| | | | |
|---|---|---|---|
| Claimant's Name: | | | |
| Physician's Name: | | | |
| Phone Number: | | | |
| Date of Injury: | | Date of Consultation: | |
| Diagnosis/History of injury: | | | |

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

Please mark (x) the anatomical location below:







| | | | | |
|---|---|---|---|---|
| Injury Type: | ☐ Amputation | ☐ Bruising | ☐ Concussion | ☐ Cut |
| | ☐ Dental | ☐ Dislocation | ☐ Fracture/Break | ☐ Death |
| | ☐ 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 |

Marsh

| | | |
|---|---|---|
| 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 AFL? | | |

Marsh

## PHYSICIAN'S DECALARTION

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, _____ (Medical Practitioner's Name) examined _____ (Claimant's 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: | |

## MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, JLT Risk Solutions Pty Ltd
and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('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 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

**Echelon Australia Pty Ltd (ABN 96 085 720 050) is a part of the Marsh & McClennan Companies (MMC) Group of Companies. Echelon is appointed claims manager for all Personal Accident Cover claims on behalf of the Insurer and Trustee.*