Marsh Personal Accident Claim Form

AusCycling National Insurance Program

Who Should Complete this claim form?

You should complete this form if:

- ✓ You are an Insured Person – AusCycling Member, official coach and or volunteer; and
- ✓ You have sustained an injury – whilst participating in cycling 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:

What is covered?

- ✓ Non-Medicare Medical Costs (commonwealth legislation prevents reimbursement of Medicare Costs including the Medicare Gap).
- ✓ Loss of Income
- ✓ Death & Other Capital Benefits

How much can I claim?

Non-Medicare Medical Costs	Loss of Income
85% Reimbursement	85% Reimbursement
$7,500 maximum per claim	$500 maximum per week
$75 excess per claim	28 day elimination period

How to lodge a Personal Injury Claim:

1. Complete all sections of this form (Skip section C if loss of income is not being claimed)
2. Send your completed form to Marsh as soon as possible
3. Marsh will lodge the form with the insurer who will confirm receipt of your claim
4. Any further costs can be submitted to the insurer by quoting the claim number provided
5. Documents can be submitted by email and post

Email	Sport@Marsh.com
Post	Marsh Pty Ltd – 727 Collins Street, Melbourne VIC, 3008
Phone Number	1300 130 373

Important Information

- You can't claim for any services where you receive a rebate from Medicare
- 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

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Section A – Claimants Details

Claimant's Name:			
Name of Club: (only applicable if claimant is a member of a Club)			
Postal Address:		State:	
Occupation:			
Email Address:			
Date of Birth:	/ /	Gender	Male Female
Member Details:	AusCycling Member Race Day Licence	Member Number: Licence Number:	
Involvement:	Lifestyle Member ( ) Race Off-Road Member ( ) Race All Discipline Member ( ) Non-riding (Judge, Director, Volunteer) ( ) Coach/Instructor ( ) Other (please specify): ( )		
What sections of the policy are being claimed?	Non-Medicare Medical Expenses ( ) Loss of Income ( ) Other (please specify): ( )		

Injury Details

When did the accident occur?	Date		Time	
Club Name		Event Name		

Describe your injury and how it happened:

Discipline at the time of injury: (please tick)		Was your activity at the time of the accident? (please tick)	
Mountain Bike	( )	Officially organised event	( )
BMX	( )	Sanctioned fundraising/social event	( )
Road	( )	Official Training	( )
Track	( )	Unofficial Training	( )
Other:		Traveling to and from activity	( )

	Bike couriering / riding for fare ( ) General Commuting (e.g. to work) ( ) Other:

Surface at point of injury? (please tick)		Which of the following best describes the location of your crash? (please tick)	
Road	( )	Within the metropolitan area of a capital city	( )
Bike Path	( )	In a regional city/town	( )
Dirt/Gravel	( )	In a rural or remote area that is not part of a city or town	( )
Velodrome	( )	Other:	
Other:			

Weather Conditions? (please tick)		During the crash you were… (please tick yes or no)		
Fine	( )	Wearing a helmet	Yes	No
Raining	( )	Wearing any reflective clothing	Yes	No
Wet (recently rained)	( )	Using a front light	Yes	No
Windy	( )	Using a rear light	Yes	No
Extreme Heat	( )			
Extreme Cold	( )			

Which of these scenarios best describes the vehicles/road users involved in your collision? (please tick)	
Only I was involved in the crash (e.g. fall)	( )
Bike-pedestrian crash	( )
Bike-bike	( )
Bike-Motor Vehicle	( )
Other:	

Advise when you did (or expect to):			
Cease Work	/ /	Resume Work	/ /
Do you have Private Health Insurance?	If yes, please provide fund name:		
Ambulance Membership:		YES	NO
Have you ever had this injury or similar injuries in the past?	If yes, please advise when: / /		

Payment Details			
Bank Name:		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 Cycling activity and is not a pre-existing illness or condition.
B. You have viewed, read and understood the Product Disclosure Statement (PDS) at au.marsh.com/sport
C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing coststhat 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, 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 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.

Date	

Claimant's Signature:

*(*Parent or Guardian if under 18 years)*

Section C – Loss of Income

(Only complete this section if you are claiming for Loss of Income)

(Please tick the box)	YES	NO
1. Can you claim compensation from any other policy that includes loss of income benefits?		
2. Have you ever made previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged any other income earning employment since you have been injured?		

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

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 weekly 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?						
If YES, what date did the Employee return?						
SALARY RECEVIED						
During the period of incapacity, has the Employee received a salary?						
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: 1. You are the Claimant's current employer (or accountant if the claimant is self-employed) 2. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate, 3. 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

PHYSICIAN'S REPORT

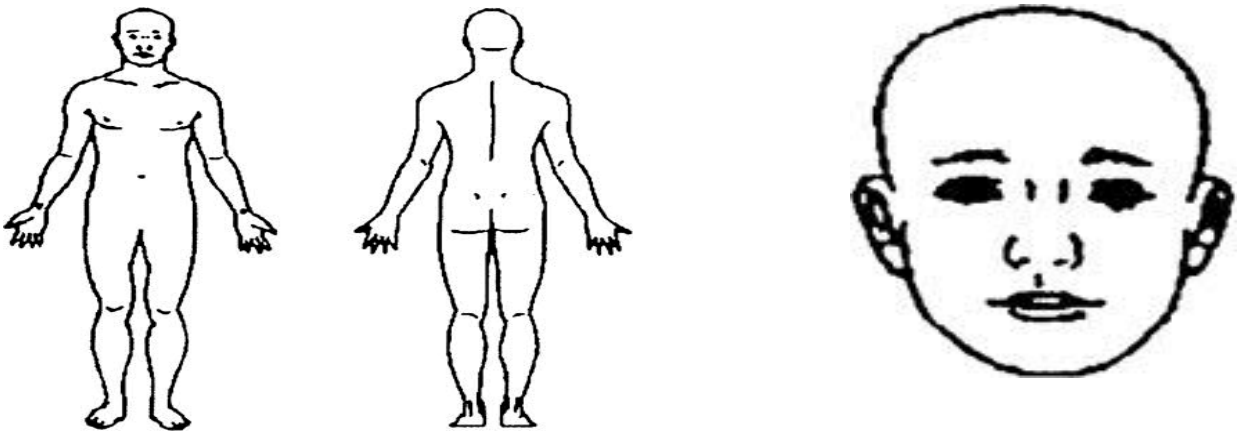
This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH

Claimant's Name:			
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 (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

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 Cycling?		

Physician's Declaration
By signing the declaration below, you confirm and agree to the following: 1. You have examined the Claimant's injury as described on this form; 2. You declare that all information provided by you and supplied herein is true and accurate.
Physician's Signature:

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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)

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:

You have examined the Claimant's injury as described on this form;

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 MARSH Sport's web site https://au.marsh.com/sport/auscycling.html

DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty of disclosure under the Insurance Contracts Act 1984 (Cth) to tell us anything that you know, or could reasonably be expected to know, may affect the insurer's decision to insure you and on what terms. You have this duty until the contract of insurance is entered into. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

If we ask you questions that are relevant to the insurer's decision to insure you and on what terms, you must tell us anything that you know and that a reasonable person in the circumstances would include in answering the questions. Also, we may give you a copy of anything you have previously told us and ask you to tell us if it has changed. If we do this, you must tell us about any change or tell us that there is no change. If you do not tell us about a change to something you have previously told us, you will be taken to have told us that there is no change.

You do not need to tell us anything that: reduces the risk insured, or is common knowledge, or the insurer knows or should know as an insurer; or the insurer waives your duty to tell them about.

If you do not tell us something:

If you do not tell us anything you are required to, the insurer may cancel your contract or reduce the amount it will pay
you if you make a claim, or both. If your failure to tell us is fraudulent, the insurer may refuse to pay a claim and treat
the contract as if it never existed.

If you are in any doubt as to the extent of the duty of disclosure or whether a piece of information ought to be disclosed, just contact your Marsh Client Risk Adviser.

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

Marsh Pty Ltd (ABN 86 004 651 512, AFSL 238983)(“Marsh”) arrange the insurance and is not the insurer. This form contains general information, does not take into account your individual objectives, financial situation or needs and may not suit your personal circumstances. For full details of the terms, conditions and limitations of the covers and before making any decision about whether to acquire the product, refer to the specific policy wordings and/or Product Disclosure Statements available from Marsh on request. If this communication contains personal information we expect you to treat that information in accordance with the Australian Privacy Act 1988 (Cth) or equivalent. You must advise us if you cannot comply.