CORPORATE
SERVICES
NETWORK

Corporate Services Network Pty Ltd
GPO BOX 4276
Sydney NSW 2001
t. +61 2 8256 1770 **f.** +61 2 8256 1775
ABN 30 074 864 609

ACCIDENT/ILLNESS CLAIM

Hints and tips about completing your claim form

This should only take about 10 - 15 mins. We want to settle your claim for you as quickly as we can. If insufficient information is provided this may delay determination of liability on your claim.

How can I check the progress of my claim?
Please contact Corporate Services Network on 02 8256 1770 or claims@csnet.com.au and advise the claim number you received from the acknowledgement notification.

What you need to do

1. **Complete Insured & Claimant Details.** Insured is the name of the Policy Holder, Claimant is the person making the claim
2. **DECLARATION OF EARNINGS** - Provide a copy of your players contract
3. Sign and date boxes 1 and 2 in the Declaration and Authorisation section on Page 5
4. Your Doctor must complete in full the Attending Physician's Statement
5. Scan and email the claim form through to **claims@csnet.com.au**

WE CANNOT PROCEED WITH THE CLAIM WITHOUT THIS INFORMATION.

Return the completed form to your Financial Services Provider or mail to **Corporate Services Network, PO Box 4276, Sydney NSW 2001** or **claims@csnet.com.au**

Corporate Services Network Pty Ltd does not generally pay for the cost of obtaining documentation to support a claim.

IMPORTANT: CORPORATE SERVICES NETWORK Pty Ltd IS PROHIBITED BY FEDERAL HEALTH LEGISLATION (INCLUDING THE HEALTH INSURANCE ACT 1973 (Cth)) FROM PAYING ANY MEDICARE REBATE INCLUDING THE MEDICARE GAP

For Example:
A student breaks their arm whist playing on the school playground

- Doctor's Fee $100.00
- Less Medicare Refund $60.00
- Medicare Gap $40.00

**The Medicare Gap is NOT claimable under this policy*

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POLICY NO.

Insured Details

Club's Name							
Player's Name							
Address							
	Suburb		**State**		**Postcode**		
Contact Numbers	**Home**		**Work**				
	Mobile		**Email**				
Date of Birth (dd/mm/yyyy)		**Height**	cm	**Weight**	kg	**Sex**	Male Female
Primary Occupation		Secondary Occupation (if any)					

Claimed Condition Details

Give a full description below of the condition/s for which you are claiming.

1. Date Injury Sustained?		**Time**	AM PM
2. What injuries did you receive?			
3. Please describe how the injury occurred	Training During Match		

4. Have you previously been treated for a similar or same injury? No Yes *If Yes, give details.*

Condition	
Date of past condition	
Treated by:	

5. Have you sustained an injury to this body part previously, if so please provide details? No Yes
(Please attach separate sheet if insufficient)

a) Are you making or entitled to make any other insurance or compensation claim in respect of this disability?

Sick leave	No	Yes	Other government benefits	No	Yes
Private health fund	No	Yes	Superannuation life insurance	No	Yes
Name of fund(s)/insurance company					

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you date you returned to play.

Functional Capacity

6. When did you become unable to play football as result of your injury?	**Date**		**Time**	am/pm
7. If still disabled, when do you expect to return to playing?	**Date**		**Time**	am/pm
8. If you have returned to functional capacity, when were you able to again perform:				
Fit to train?	**Date**			
Fully rehabilitated to return to play?	**Date**			

Medical History

9. Details of all attending physicians.

Doctor's name	Address	Telephone number

10. What other medical or surgical treatment has been received in the 2 years prior to this injury?

Date	Nature of treatment	Doctor's name	Address

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work

Club Declaration

Insured Persons Name:	
Club	

Club Declaration / Claimed Event Statement:
You confirm that the claimed event and condition as outlined above occurred whilst the insured person was engaging in any activity arising out of or in the course of their employment with an APL club

Please confirm the activity which the insured person was engaging in at the time of the claimed event:

- ☐ Club Match
- ☐ Training / Practice
- ☐ Travel Between Match/es
- ☐ Tour (away from home)
- ☐ Overseas Club Trial/s
- ☐ Club Social Activities
- ☐ Appearances
- ☐ Charity / Promotional Activity

Print Name	
Signature	

Banking Details

Account name		Bank name	
BSB		Account number	

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Privacy Statement, Medical Authority and Declaration

Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorized access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770.

Medical Authority and Declaration

- I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.
- I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN's Privacy Policy and this document.
- In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.
- I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.
- I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim.
- I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.
- I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.
- I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Insured	1.		Date *(dd/mm/yyyy)*	
Witness Signature	2.		Date *(dd/mm/yyyy)*	

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ATTENDING PHYSICIAN'S STATEMENT

Important – your doctor must complete the attending physician's statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement.

Any charge for this statement must be borne by the patient. Please complete all sections.

Patient's Details

Patient's name (block letters)								
Address								
	Suburb		**State**		**Postcode**			
Date of Birth (dd/mm/yyyy)		**Height**	cm	**Weight**	kg	**Sex**	Male	Female
Diagnosis (if any fracture or dislocation, describe nature and location i.e. Simple, Compound)								
Describe how the injury occured								
Is this condition	an injury		or	an Illness				
Does the patient have any other injury or illness that is contributing to the condition?	No		Yes		If Yes, give details			
Date of onset/first symptoms?								
When did the patient first consult you for this condition?								
Has the patient ever had the same or similiar condition?	No		Yes		If Yes, give details			
Date of onset/first symptoms?		**Diagnosis**						
How long have you been the patient's usual doctor/medical practice?								
If the patient has been hospitalised please provide;	**Admission date**		**Discharge Date**					
Hospital name								

Patient's Details (continued)

Has the patient had surgery or is it anticipated?		No	Yes If Yes, give details
Date performed or anticipated		**Hospital name**	
Please outline all treatment received to date in the management of your patient's condition. Please include any relevant medical documents, reports or investigation scans.			
Is the patient still disabled?			
No When was the patient considered fit to play?		Yes How long will the patient be;	
		totally disabled (considered medically unable to play)	**partially disabled** (considered medically able to perform part of their normal duties i.e. able to train)
		From	**From**
		To	**To**
Signature of medical practitioner		**Date**	
Name (Print)		**Qualifications**	
Address			
	Suburb	**State**	**Postcode**
Telephone			

Complaints and Dispute Resolution

If you are unhappy with our service, a decision or the process, you may make a complaint in accordance with our complaints handling procedure. Details of our insurance complaints handling procedure can be obtained from our website at www.csnet.com.au

How to Contact Us

- Mail GPO BOX 4276 Sydney NSW 2001
- Email claims@csnet.com.au
- Website www.csnet.com.au
- Telephone +61 2 8256 1770
- Facsimile +61 2 8256 1775

Corporate Services Network Pty Ltd ABN 30 074 864 609, CSN is an Authorised Representative (A/R # 001294637) of Gallagher Bassett Services Australia (AFSL #: 530867).