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Personal Injury Claim Form

Australian Football National Risk Protection Program

IMPORTANT INFORMATION

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- You are an Insured person – 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.marsh.com/au/financial-services-guide.html

WHAT IS COVERED?

Non-Medicare Medical Costs

Death & other Capital Benefits

Loss of Income cover is available as an optional extra that can be purchased for additional premium.

HOW MUCH CAN I CLAIM?

The following table outlines the various levels of cover within this Program.

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursement	75% Reimbursement	90% Reimbursement	90% Reimbursement
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim

- All clubs receive, at least, the Bronze level of cover at the start of each period of cover.
- Clubs/Leagues may choose to upgrade to a higher level of cover for an additional premium.
- Upgraded cover is valid only from the date of purchase.
- If you do not know what level you have, please contact your club and/or league for details.

HOW TO LODGE A PERSONAL INJURY 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

HOW TO SEND COMPLETED FORMS

Email:	sportsclaims@echelonaustralia.com.au		
Post:	Echelon Claims Services – GPO Box 1693 Adelaide SA 5001		
Fax:	08 8235 6450	Phone No:	1800 640 009

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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.

WHO IS ECHELON?

Echelon Australia Pty Ltd (Echelon) is a business of Marsh & McLennan Companies (MMC). Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the AFL National Risk Protection Program.

WHO IS MARSH?

Marsh is the appointed broker for the AFL National Risk Protection Program and is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries.

SECTION A - CLAIMANTS DETAILS

Claimant's Name:				
Postal Address:				
Occupation:				
Email Address:		Phone Number:		
Date of Birth:			☐ Male	☐ Female
Date of Injury:		Time Of Injury:		☐ AM ☐ PM
Club Name:				
Association/League Name:				

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

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INJURY RESEARCH DATA					
Session:	☐ Playing		☐ Training		☐ Travelling
	☐ Event		☐ Warmup/down		☐ Other
Injured Person:	☐ Player	☐ Umpire	☐ Official	☐ Trainer	☐ Other
Grade:	☐ Senior	☐ Reserve	☐ Junior	☐ Not Applicable	
Surface Conditions:	☐ Wet		☐ Dry		☐ Muddy
	☐ Indoor		☐ Other		
Period:	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 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

PAYMENT DETAILS			
Bank:		Account Name:	
BSB:		Account Number:	

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CLAIMANT DECLARATION

By signing the declaration below, you confirm and agree to the following:

1. The injury was sustained accidentally during a football activity and is not a pre-existing illness or condition.
2. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.marsh.com/au/financial-services-guide.html
3. 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).
4. 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.
5. 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.
6. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.
7. 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.
8. 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:	

SECTION B CLUB DETAILS

Claimant's Full Name:			
Club Name:			
Club Contact:			
Position within Club:			
Email Address:		Phone Number:	

INJURY DETAILS

League/Association Name:				
Registration Details:			☐ Yes	☐ No
Non-Medicare Cover: (If Known) What Cover Level has the Club purchased for this Period of Cover? (Optional – if unsure please leave blank)	☐ Bronze (50%)	☐ Silver (75%)	☐ Gold (90%)	☐ Platinum(90%)
Loss of Income Cover: (If Known) Has the club purchased Loss of Income this year? If YES what is the weekly limit purchased by the Club if known?	☐ Yes	☐ No	$_____ Per Week	
Date of Injury:		Time Of Injury:		☐ AM ☐ PM

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Circumstances:	☐ Playing	☐ Training	☐ Travelling	☐ Other (Please Specify)	
Opposition Club Name: (If Applicable)					
Ground/Location Where the Injury Occurred:					

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:	

SECTION C – LOSS OF INCOME (TO BE COMPLETED BY THE CLAIMANT)

Do you wish to claim Loss of Income Benefits?	☐ Yes	☐ No

IF YOU ARE NOT CLAIMING LOSS OF INCOME BENEFITS PLEASE DO NOT COMPLETE THIS SECTION. PLEASE PROCEED TO SECTION D

The elimination period is a period of consecutive days during which no benefits are payable. The elimination period under the insurance policy for loss of income benefits is 14 days or your sick leave entitlement as an employee whichever is greater.

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

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TO BE COMPLETED BY THE CLAIMANTS EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)				
Claimant's Name:				
Employer/Business:				
Contact Person:				
Postal Address:				
Email Address:				
Phone (Bus. Hours):			Mobile:	
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed
Employment Details If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.				
Employee's NET weekly salary:			$	
Employee's GROSS week salary:			$	
Date Employee commenced with company:				
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.						

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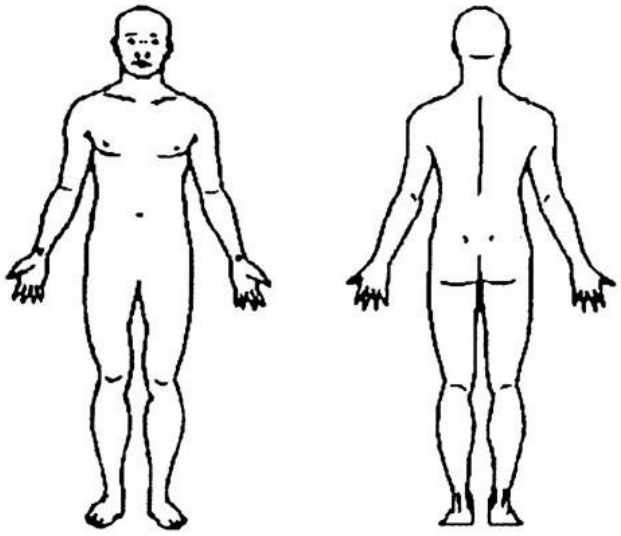
EMPLOYERS DECLARATION:			
By signing the declaration below, you confirm and agree to the following: A. You are the Claimant's current employer (or accountant if the claimant is self-employed), B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate, 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:	

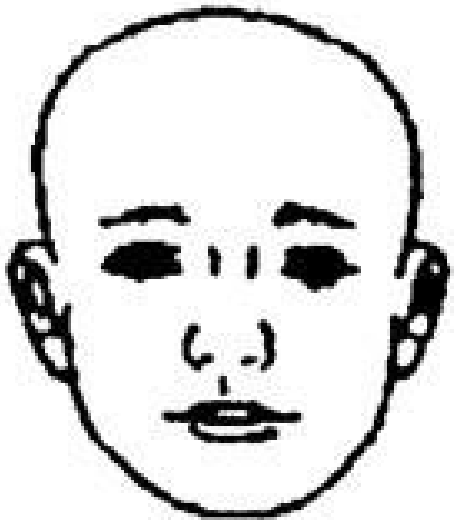
SECTION D - PHYSICIAN'S REPORT			
THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH - This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.			
Claimant's First Name:		Claimant's Last Name:	
Physician's Name:		Phone Number:	

INJURY CONSULTATION			
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:





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Injury Type:	☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut	☐ Death
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Rupture	☐ Sprain
	☐ Strain	☐ Fatigue/Debilitation			
First Medical Treatment:					
Name of attending physician:					
Date of treatment:					
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's:				☐ 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					

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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 Football?			
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 _____
(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:
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 au.marsh.com/sport

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

  Post – PO Box H176, Australia Square NSW 1215