

PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

NON-MEDICARE MEDICAL AND LOSS OF INCOME CLAIMS ONLY

For Policy Wordings, Summary of Cover and other information relating to Personal Injury claims, please refer to:

www.jlt sport.com.au/afl

Claims Enquiries:
1800 640 009

Please send your completed claim form and attachments to:

Echelon Claims Services PO Box 7170, Hutt Street, SA 5000	OR	Fax: (08) 8235 6450
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General Enquiries:
1300 130 373

HOW TO LODGE A PERSONAL INJURY CLAIM:

- Step 1:** Access a *current* claim form via www.jlt sport.com.au/afl or call Echelon on 1800 640 009
- Step 2:** Complete *all* relevant sections of the claim form.
- Your claim form may be returned if there is important information missing
 - For assistance contact Echelon on 1800 640 009
- Step 3:** Send your claim form to Echelon *as soon as possible (within 180 days)* from the date of injury.
- If treatment of the injury is likely to continue beyond 180 days, please send through your claim form with any current receipts received and contact Echelon for further assistance.
- Step 4:** Echelon will confirm receipt of your claim or make contact with you should they require more information.
- Please contact Echelon directly if you have not received confirmation of your claim within 2 weeks from the date of lodgement.

IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS: *Please read the following information carefully*

Who is Echelon?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of Jardine Lloyd Thompson Pty Ltd. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the National Risk Protection Program.

We legally can not reimburse you for Medicare-related costs:

The Health Insurance Act (Cth) 1973 does not permit the Insurer or the Trustee to reimburse you for any costs associated with medical treatments registered with Medicare (this includes the Medicare Gap).

Only Non-Medicare Medical Treatments can be reimbursed (as per the Policy Wording):

- All treatments must be certified as "necessary" by your physician. i.e. Doctor, physiotherapist, etc
- Please refer to JLT Sport's web site (www.jlt sport.com.au/afl) for benefits, excesses and special conditions/exclusions

Attach Original Receipts:

- Send original receipts with your claim form (unless retained by your private health fund).

If you have Private Health Cover:

- Claim on your private health fund first and attach a copy of their rebate advice to this form.

Privacy of your personal details:

- We collect, store and use your personal details in-line with the Privacy Act (Cth) 1988. For a copy of our Privacy Statement please contact JLT Sport on 1300 130 373 or view it online www.jlt sport.com.au

Examples of items covered by Medicare. *We can not reimburse you for these costs.*

- Doctor
- Surgeon
- Surgeon's Assistant
- Anaesthetist
- X-rays
- MRI Scans*
- Public Hospitals

Examples of Non-Medicare items. *Claimable as per the Policy Wording.*

- Ambulance
- Physiotherapist
- Dental
- Private Hospital Accommodation
- Chiropractor
- MRI Scans*

PLEASE NOTE:
* MRI scans are generally claimable through Medicare, however please check with your referrer and/or provider to confirm if this is the case prior to lodging your claim.

CLAIM FORM CHECKLIST: *Please use the checklist below to ensure ALL sections are completed as required.*

SECTION A:	SECTION B:	SECTION C:*	SECTION D:
<input type="checkbox"/> Claimant's details <input type="checkbox"/> Injury details <input type="checkbox"/> Injury research <input type="checkbox"/> Signed by Claimant	<input type="checkbox"/> Club declaration <input type="checkbox"/> Signed by authorised club representative	<input type="checkbox"/> Confirmation of Loss of Income Cover <input type="checkbox"/> Employment Details <input type="checkbox"/> Signed by Employer	<input type="checkbox"/> Injury details <input type="checkbox"/> Signed by your physician

* Section C must be completed only when claiming for Loss of Income. Loss of Income is an OPTIONAL cover. Before lodging your claim, please obtain verification from your club or association/league that you are covered for Loss of Income Benefits in Season 2009.

CLAIM FORM SECTION A:

THIS SECTION MUST BE COMPLETED IN FULL BY THE CLAIMANT OR A LEGAL GUARDIAN IF THE CLAIMANT IS UNDER 18 YEARS OF AGE.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE SEND YOUR COMPLETED CLAIM FORM AND ORIGINAL RECEIPTS TO:
ECHOLON CLAIMS SERVICES, PO BOX 7170, HUTT STREET, SA 5000 | OR FAX: (08) 8235 6450
 PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.

1 _____ Claimant's Surname	2 _____ Claimant's First Name	3 <u>Male / Female</u> Gender	4 _____/_____/_____ Date of Birth (DD/MM/YYYY)
5 _____ Claimant's Personal Mailing Address		State _____	6 _____ Post Code
7 _____ Claimant's Occupation (if applicable)		8 () _____ Work Phone Number	9 _____/_____/_____ Date of Injury (DD/MM/YYYY)
10 _____:_____ am/pm Approx. Time of Injury (HH:MM)			
11 _____ Club Name		12 _____ League/Association Name	
13 Describe the injury and how it happened (please use additional pages if required). _____ _____			
14 Describe any other factors that may have contributed to your injury (leave blank if not applicable). _____			
15 Where did the injury occur? <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor			
16 What was the surface type at the time of injury? <input type="checkbox"/> Grass <input type="checkbox"/> Indoor surface <input type="checkbox"/> Concrete/asphalt <input type="checkbox"/> Other _____ <small>Please specify</small>			
17 What were the weather conditions? <input type="checkbox"/> Fine <input type="checkbox"/> Rain <input type="checkbox"/> Showers <input type="checkbox"/> Extreme heat <input type="checkbox"/> Extreme cold <input type="checkbox"/> Other _____ <small>Please specify</small>			
18 What were the surface conditions? <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Muddy <input type="checkbox"/> Hard			
19 What were your circumstances at the time of injury? <input type="checkbox"/> Playing <input type="checkbox"/> Training <input type="checkbox"/> Travelling <input type="checkbox"/> Other _____ <small>Please specify</small>			
20 In which quarter/period were you injured? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th			
21 How did the injury occur? <input type="checkbox"/> Fall <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Overuse <input type="checkbox"/> Other _____ <small>Please specify</small>			
22 Please indicate when you intend to resume the following activities. If exact dates are not known, please provide approximates. _____/_____/_____ <input type="checkbox"/> N/A _____/_____/_____ _____/_____/_____ When will you resume WORK? When will you resume TRAINING? When will you resume PLAYING?			
23 Do you have private health cover? <input type="checkbox"/> YES <input type="checkbox"/> NO			
24 If yes, what is the name of your private health fund? _____			
25 Please indicate the covers offered by your private health fund <input type="checkbox"/> Dental costs <input type="checkbox"/> Physiotherapy costs <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital costs			
26 Are you a member of the Ambulance Service? <input type="checkbox"/> Yes <input type="checkbox"/> NO			
27 Please indicate to whom re-imburement cheques are to be made payable: <input type="checkbox"/> Myself <input type="checkbox"/> Other			
Contact Person _____		Cheque made payable to _____	
Address _____		State _____	Post code _____
I, the undersigned, hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other authorised members of the JLT Sport (Australian Football National Risk Protection Programme) Discretionary Trust Arrangement. I allow this information to be used as part of the Trust's risk management processes and reporting criteria. I authorise any hospital, physician or other person who has attended me or any employer, to furnish JLT Sport or its representatives 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 all records of employers. I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the forgoing particulars are true and correct in every detail. I agree that if I have made, or shall make in any further declaration in respect to said injury, any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the covers shall be void and all rights to recover there under in respect to past or future injuries shall be forfeited.			
28 _____ Claimant's signature (or Parent/Guardian if under 18 years)		_____/_____/_____ Date	

CLAIM FORM SECTION B: CLUB/LEAGUE DECLARATION

THIS SECTION MUST BE COMPLETED IN FULL BY AN AUTHORISED CLUB OR LEAGUE REPRESENTATIVE
FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE PRINT

I, the undersigned, as authorised representative of _____ hereby declare that
Name of Club/League

_____ sustained the injuries outlined on this claim form on ____/____/____
Name of Claimant Date of Injury

at _____ whilst Playing Training for _____
Time of Injury Select one Name of Claimant's Club/Team

at _____ against _____
Name of Ground/Place of Injury Name of Opposition Club/Team (if applicable)

I confirm that our club/association/league has completed all registration requirements for the 2009 National Risk Protection Programme, including the compulsory online Risk Management Education Training Module via JLT Sport's Web Site (www.jltsport.com.au/afll).

I confirm that the Claimant Has not returned to playing/training.
 Returned to playing/training on: ____/____/____
Date Claimant returned

I confirm that _____ has the following level of cover for the 2009 National Risk Protection Programme:
Name of Claimant's Club/Team

Bronze (Standard Cover) Silver Gold Platinum

Has not purchased Loss of Income Cover for Season 2009.
I confirm that _____ Has Purchased Loss of Income Cover for Season 2009 as per the details below.
Name of Claimant's Club/Association/League

Loss of Income Cover Details:
Please indicate below the Loss of Income Cover purchased by the club for Season 2009. The details provided must include the Claimant as an Insured Person.

Junior Team Senior Team Individual \$ _____ Per week 14 days 49 days
Excess Date of Purchase

CLUB/LEAGUE DECLARATION. This must be signed by an authorised club/league representative. If blank, your claim may be delayed.

Authorised Club/League Representative's name (please print)

Authorised Club/League Representative's Title/Position

Authorised Club/League Representative's signature

____/____/____
Date

Authorised Club/League Representative's contact email

Authorised Club/League Representative's contact number

UPGRADING COVER:

Please note, all clubs receive the basic minimum cover of *Bronze* at the commencement of each Policy Period. Clubs may upgrade to a higher level of cover at an additional premium. Upgraded cover is valid only from the date of purchase. For an Upgrade Form and details please visit www.jltsport.com.au/afll. The following table outlines the reimbursement for the various levels of cover within the 2009 National Risk Protection Programme:

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursement \$2,000 max. per claim \$100 excess per claim	75% Reimbursement \$2,500 max. per claim \$75 excess per claim	90% Reimbursement \$3,500 max. per claim \$50 excess per claim	90% Reimbursement \$7,500 max. per claim \$50 excess per claim
Capital Benefits	\$100,000 (\$20,000 for U18)	\$150,000 (\$30,000 for U18)	\$200,000 (\$40,000 for U18)	\$250,000 (\$50,000 for U18)

* All clubs within the Victorian Country Football League receive Silver cover as the basic minimum cover.

LOSS OF INCOME BENEFITS:

Please note, Loss of Income benefits are not included within the standard cover provided by the National Risk Protection Programme. Clubs/Leagues must purchase this cover for an additional premium as per JLT Sport's Optional Upgrade Procedures (for details please refer to www.jltsport.com.au/afll).

Loss of Income Benefits provide reimbursement for either 80% of the player's net weekly income or the maximum amount per week as purchased by the club/league – whichever is the lesser. Coverage is for a maximum of 52 weeks and a 14 or 49 day elimination period applies (as per the cover purchased). This means that the claimant must lose 14 or 49 days income due to the injury before a claim is payable.

If claiming for Loss of Income Benefits you must complete Section A and Section B of this form, and have Section C completed by your employer. Section D must be completed including the Incapacity to Work Statement completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

CLAIM FORM SECTION D: PHYSICIAN'S REPORT (CONTINUED)

15 Have you referred the patient to any other services or treatment? Yes NO

16 If YES, please specify the approximate number of treatments required.

Physiotherapy _____
Treatments required

Chiropractics _____
Treatments required

Surgery _____
Treatments required Please provide surgery details _____

Other _____
Treatments required Please provide details _____

17 Has the patient been able to do any work since the injury occurred? Yes NO

18 What date do you advise the patient to return to playing football? _____
Date advised to return to football

I, the undersigned, declare that I have examined the Claimant's injury as described on this form. I hereby declare that all information I have provided on this form is true and accurate as at the date of examination.

19 _____
Physician's name (please print) Physician's Phone Number

Physician's signature _____
Date

Incapacity to Work Statement *Only complete this section if claiming for Loss of Income.*
Incapacity to Work Statement must be completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist).
It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

I, _____ examined _____ on ____/____/____.
Medical Practitioner's name Claimant's name Date of Examination

In my opinion, this person is/has been unfit for work from ____/____/____ to ____/____/____ inclusive.
First date of incapacity to work Last date of incapacity to work

Please provide any further comments/remarks in regard to your assessment of this injury/condition.

Medical Practitioner's Name Medical Practitioner's Phone Number

Medical Practitioner's Address State Post Code

Medical Practitioner's Signature _____
Date