Personal Accident Claim Form

Football NSW Insurance Programme

Please read this page before completing the claim form

Dear Member,

Thank you for your claim form request. This letter contains important information relevant to your claim. Please read it carefully and make sure you understand its contents.

We require the claim form to be fully completed and returned within 120 days of your injury.
DO NOT wait until treatment is complete before submitting the claim form.

1. The Physicians Report on page seven (7) must be completed by a legally qualified medical practitioner, doctor, surgeon or dentist who is providing treatment for your injury.
2. For claims under the Loss of Income Benefit, your employer must complete the Employer's Statement on page six (6). A Return to Work Statement from your employer is also required before processing can be completed. If you are self-employed, the Statement on page six (6) showing income details must be completed by your accountant.
3. Important note regarding claims for medical expenses: We do not provide cover for any account that is fully or partially covered by Medicare. This means we do not cover expenses claimable from Medicare or the Medicare Gap. The reason for this is we're not permitted by law to do so. Please do not send us any account/receipt that is covered by Medicare or Medicare statements. Do not wait for any account/receipt before sending.
4. Please send all receipts for Non-Medicare medical expenses. If you are claiming from a private health insurer, please send those statements along with your receipts.
5. Insurers will commence working on your claims immediately however, claims cannot be settled (entitlements calculated) until all accounts have been paid and refunds from your private health insurer have been obtained.
6. There are excesses on claims for medical expenses and on claims for loss of earnings. For precise details and information regarding policy maximums and excesses, please contact your club or association or visit www.gowgatessport.com.au/football.
7. Gow-Gates values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement, please visit our website at www.gowgates.com.au
8. Please note that medical cover is limited for 12 months from the date of accident.

If you have any queries, please call us immediately on 02 8267 9999.

How to Lodge a Personal Injury Claim

Please send all completed claim forms to Gow-Gates Insurance Brokers:

SPORTS CLAIMS TEAM
Gow-Gates Insurance Brokers Pty Ltd
GPO Box 4731, Sydney NSW 2001
sportsclaims@gowgates.com.au

What should I send with my claim?

Receipts- If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to Gow-Gates.

Retain a copy- We recommend you retain a copy of all receipts and your Claim Form records.

Private Health Insurance (if applicable)- Please claim through your Private Health Fund first and then send Gow-Gates a copy of your Private Health rebate advice.

Claims Conditions

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to Gow-Gates within 120 days from the date of injury.

- Medical treatment must be certified as necessary by a legally qualified medical practitioner.
- Subject to the policy, any treatment **must be completed within 12 calendar months from the date of injury**. Physiotherapy, chiropractic and or similar treatment **must first be referred by a legally qualified medical practitioner**.
- All certifications and evidence required by Gow-Gates must be provided by you upon request and at your expense (if applicable). Back dated medical certificates will not be accepted, and medical certificates from a legally qualified medical practitioner can only be accepted and must be provided at least every four (4) weeks for loss of income benefits.
- Due to government legislation there is no cover available for any medical expense for which a benefit is or can be claimed through Medicare including the balance of monies due or payable by You after the deduction of any Medicare benefit or rebate from the actual medical expense incurred (commonly known as the "Medicare Gap").

Code of Practice and Privacy Act

Gow-Gates Insurance Brokers Pty Ltd proudly supports the Insurance Brokers Code of Practice, and are committed to raising standards of services to our customers. This voluntary code sets out the minimum standards we will uphold in the services we provide to you.

The Privacy Act sets out how we are able to collect, use, disclose and protect your personal information. It also describes the circumstances for you to access and, if necessary, correct your personal information. You may access your personal information by contacting our office on 02 8267 9999. The information we collect is used to assist us to provide you with our general insurance products and to manage our relationship with you. If you do not wish to provide us with your personal information, we will not be able to supply our products to you.

Before you commence filling in this form, please make sure you have read and fully understood the dialogue on the front of the claim form as it contains important information relating to your claim. If you have any questions at all about its content or meaning, please contact the Gow-Gates office.

Section A: Claimant's Details

Name of Claimant:			FFA Number:	
Postal Address:				
Date of Birth:	/ /		Sex:	☐ Male ☐ Female
Contact Details:	Phone:		Mobile:	
	Email:			
Club Name:				
Association Name:				

Injury Data

Date of Injury: _____ / _____ / _____ Time of Injury: _____

Session:	☐ Playing	☐ Training	☐ Travelling	☐ Event	☐ Warm up / down	☐ Other
Location:	☐ Indoor	☐ Outdoor				
Injured Person:	☐ Player	☐ Referee	☐ Official	☐ Trainer	☐ Other	
Grade: Player	☐ Senior	☐ Junior	☐ Not Applicable			
Surface Type:	☐ Grass	☐ Synthetic Grass	☐ Indoor	☐ Timber	☐ Asphalt	☐ Concrete
Weather Conditions:	☐ Fine	☐ Rain	☐ Extreme Heat	☐ Extreme Cold	☐ Other	
Surface Conditions:	☐ Wet	☐ Dry	☐ Muddy	☐ Indoor	☐ Other	
Half:	☐ 1st	☐ 2nd				
Resumption date(s):	When will you resume work? _____ / _____ / _____					
	When will you resume training? _____ / _____ / _____					
	When will you resume playing? _____ / _____ / _____					
Private Health Cover:	Do you have Private Health Insurance? ☐ Yes ☐ No		If yes, what is the name of your provider? _____			
Private Health Coverage:	☐ Dental	☐ Physiotherapy	☐ Ambulance	☐ Hospital		
Ambulance Membership:	☐ Yes	☐ No				

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

Payment Details

PLEASE NOTE – For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

Please select how you would like to be reimbursed for this claim?

☐ Mail cheque ☐ Direct bank deposit (Please provide details below)

Bank name:			
Beneficiary name:			
BSB number		Account number:	

PLEASE NOTE

Copies of receipts and all statements of any benefits received from any source must be sent to Gow-Gates as soon as possible. Failure to do so will result in settlement delays. Please also remember to inform us in writing when your treatment is complete. This will also reduce delays in settlement of your claim.

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

Section B: Declaration and Authorisation by Injured Person, Parent or Legal Guardian

I hereby authorise any hospital, physician, medical practitioner, medical specialist or any other person who has attended me and / or employer of mine, past or present, to furnish Gow-Gates and / or its representatives with any and all information with respect to any sickness or injury, medical history, consultants, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers including verification or my earnings.

I acknowledge that any personal information that I have or will provide to Gow-Gates is necessary for and will be used in processing, assessing, investigation or review of this claim. I hereby authorise Gow-Gates and / or its representatives and consent to Gow-Gates and / or its representatives and its authorised agent to disclose any personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed / authorised broker, account broker, and / or broker of the entire / body corporate / organisation insured (Insured), State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personal information (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, I can contact the Gow-Gates office.

I agree that a photocopy / scanned copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

Name:

Signature of Claimant (or Parent / Guardian if under 18 years of age):

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for prosecution.

Note: Please check this form has been fully completed as any omissions may delay your claim.

Section C: Associations & Club Declaration

Name of Claimant:				
Club Name:				
Club Contact Details:	Phone:		Mobile:	
	Email:			
Association Name:				

Injury Details

Date of Injury: _____ / _____ / _____ Time of Injury: _____

Circumstances:	☐ Playing ☐ Training ☐ Travelling ☐ Other
Opposition Club Name (if applicable):	
Ground Location (where it occurred):	
Resumption date(s):	Has the claimant returned to training? ☐ Yes ☐ No If yes, date Claimant returned? ____ / ____ / _____
Is the player registered?	☐ Yes ☐ No FFA Registration Number:

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 Association (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-exsisting illness or condition to the best of my knowledge

Club Representative's Name:

Club Representative's Signature:

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for prosecution.

Association 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 Association (as above).

B. Confirm the Claimant is appropriately registered with the Club and Association referred to in this claim application.

Association Representative's Name and Title:

Association Representative's Signature:

Date:

Warning: Persons found to have lodged a fraudulent claim are liable for prosecution.

Section D: Employer's Statement (ONLY complete thi section if you are claiming loss of Income Benefits).

To be completed by the Claimant's Employer (or Accountant if Self-Employed)

Claimant's Name:				
Employer/Business:				
Occupation:				
Postal Address:				
Contact Details:	Phone:		Mobile:	
	Email:			
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	
	_____ / _____ / _____ Date employee ceased work	_____ / _____ / _____ Date expected to resume duties		
Returned to Work:	Has the claimant returned to work? ☐ Yes ☐ No	If yes, what date did the Employee return? ____ / ____ / _____		
Salary Recieved:	During the period of incapacity, has the employee recieved a salary? ☐ Yes ☐ No If yes, what for? Sick Leave: from ____ / ____ / _____ to ____ / ____ / _____ Annual Leave: from ____ / ____ / _____ to ____ / ____ / _____ Other: from ____ / ____ / _____ to ____ / ____ / _____			

Employer's declaration

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

A. You are the Claimant's current employr (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 / Accountant's Name:

Employer's / Accountant's Signature:

Date:

Please check all details have been completed as this will cause delays to the claim.

Section E: Physician's Report

PLEASE NOTE

These questions are to be completed by the main doctor, dentist or surgeon, not by a physiotherapist or chiropractor.
The insured is responsible for the completion of this form and any charges incurred for its completion.

Patients (Claimant's) details:	
Name:	
Physician's Details:	
Physician's Telephone:	
Physician's Email:	
Diagnosis / History of Injury:	
Injury Location:	☐ Ankle ☐ Arm ☐ Dental ☐ Facial ☐ Foot ☐ Hand ☐ Head ☐ Internal ☐ Knee ☐ Lower Leg ☐ Shoulder ☐ Spinal ☐ Torso ☐ Upper Leg
Injury Type:	☐ Amputation ☐ Bruising ☐ Concussion ☐ Cut ☐ Strain ☐ Dental ☐ Dislocation ☐ Fracture / Break ☐ Rupture ☐ Sprain ☐ Fatigue / Dehabilitation ☐ Death
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:	

Section E: Physician's Report CONTINUED

Patients (Claimant's) details CONTINUED

Does the Claimant have any congenital defects or chronic deases?	☐ Yes ☐ No			
If YES, please provide details and a description:				
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: _____
	Chiropractics:	☐ Yes	☐ No	If yes, approx. number of treatments required: _____
	Surgery:	☐ Yes	☐ No	If yes, approx. number of treatments required: _____
	Other:	☐ Yes	☐ No	If yes, please provide details:
Has the Claimant been able to do any work since the injury occured?	☐ Yes ☐ No			

Physician's Declaration

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.

Physiciant's Name:
Physiciant'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 _____

In my opinion, this person is/has been unfit to work from _____ / _____ / _____ to _____ / _____ / _____ inclusive
First day of incapacity Last day of incapacity (estimate)

Please ensure that the dates are completed in full as incompletion will cause significant delays to the claim.

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 Name:

Physician's Signature:

Date: