

# PETANQUE AUSTRALIA

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# PERSONAL INJURY CLAIM FORM

Willis Australia Limited  
HEAD OFFICE  
Level 5, 179 Elizabeth Street, SYDNEY NSW 2000  
Phone (02) 9285 4111  
or  
local call cost only 1300 WILLIS (i.e 1300 945 547)  
Fax (02) 9283 5276  
Email: [sports.au@willis.com](mailto:sports.au@willis.com)  
Website: [www.willis.com.au](http://www.willis.com.au)

# PETANQUE AUSTRALIA

## SUMMARY OF INSURANCE COVER

### Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is \$250,000 (other than anyone under 18 years or aged between 80 to 90 years old \$10,000 maximum).

### Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$1,500 (other than anyone aged between 80 to 90 years old \$500 maximum). Claimable expenses are physiotherapy, private hospital, ambulance, dental etc, net of any recoveries from private health insurance, subject to a \$50 excess. Cover is limited to expenses incurred within 12 months from the date of injury.

### Student Assistance Benefit

Reimburses up to 100% of parent's costs incurred up to a maximum of \$250 per week for up to fifty two (52) weeks (other than anyone aged between 80 to 90 years old, with a 26 weeks maximum benefit period) being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student, subject to a 7 day excess.

### Household Help Allowance

Reimburses non-wage earners for 100% of cost incurred up to a maximum of \$250 per week for up to fifty two (52) weeks (other than anyone aged between 80 to 90 years old, with a 26 weeks maximum benefit period) being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy, subject to a 7 day excess.

### Broken Bones Benefit

Reimburses up to a maximum of \$3000 for each insured as per the scale of benefits defined in the policy. There is no benefit paid for persons aged over 80 years.

### Loss of Income

Cover for 85% of your net weekly income or up to a maximum of \$600 per week, whichever is the lesser. The benefit period is 52 weeks and the excess is 7 days. There is no benefit paid for persons aged over 80 years.

### Important Notes

This insurance cover is underwritten by:-  
Chubb Insurance Company of Australia Limited  
ABN 69 003 710 647  
Level 29, Citigroup Building, 2 Park Street  
Sydney NSW 2000

1. This information is only a summary of the cover provided. The policies with full conditions are available by contacting Petanque Australia.
2. This insurance program commenced on 7 December 2007 and expires on 7 December 2008.
3. Willis Australia Limited has arranged this insurance program to provide benefits to those registered members of Petanque Australia who, through injury or accident, incur financial loss and who would otherwise not have received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
4. Petanque Australia is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

# HOW TO MAKE A CLAIM

Dear Petanque Australia member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.
2. Please ensure that you fully complete pages 4 & 5 and sign and date the Declaration.
3. Please ensure that your Club official completes and signs the Club Declaration on page 4.
4. For claims involving Loss of Income:-
  - a) You must complete page 6 and have your employer/salary officer to complete page 6. If self employed, you must have your accountant complete these details;
  - b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 8.
5. For claims involving Non-Medicare medical expenses:-

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).

  - a) Have your Attending Physician complete the "Attending Physician" statement on page 8.
6. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

7. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to your State Petanque Association.
8. Your State Association will verify your membership and sign the statement on page 4 and forward your claim onto Willis – Level 5, 179 Elizabeth Street, SYDNEY NSW 2000. Willis will then send the documentation to Chubb Insurance Company of Australia Limited. Your reimbursement cheque will be sent to you directly by Chubb Insurance Company of Australia Limited.
9. Once your claim is registered, you can submit ongoing invoices via Chubb Insurance Company of Australia Limited – Level 29, Citigroup Building, 2 Park Street Sydney NSW 2000. Chubb Insurance Company of Australia Limited can also be reached on ph: (02) 9273 0100 should you wish to make enquiries relating to the progress of your claim.
10. If you have any further queries relating to your claim, please do not hesitate to call the Willis Sports Team on (02) 9285 4111 or local call cost only 1300 WILLIS (i.e 1300 945 547).

## PERSONAL ACCIDENT CLAIM FORM

### PLAYER DETAILS

Name of Club:	Member No (if applicable):	Given Name: Surname:
Gender (please tick): * Male      * Female	Occupation:	Date of Birth: / /
Address	State    Postcode	Email:
Phone Number (work): (   )	Home (   )	Mobile

### DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I \_\_\_\_\_ (insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Chubb Insurance Company of Australia Limited to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Chubb Insurance Company of Australia Limited and their service providers in order to assess the claim. Chubb Insurance Company of Australia Limited complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Declared at \_\_\_\_\_ In the State/Territory of \_\_\_\_\_

Signature of Claimant (or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
if under 18 years of age)

### DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: (   )
Address	State    Postcode
I, the above mentioned Petanque Australia Club Official, confirm that the claimant was a registered and Financial member of this Petanque Australia club and was an insured person as identified in the Personal Accident Insurance with Chubb Insurance Company of Australia Limited at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.	
Dated: / /	Signature of Club Official:

### STATEMENT BY PETANQUE AUSTRALIA STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered insurance member of the Petanque Australia Personal Accident Insurance Program.

Name of State/Territory:	Date: / /
Official's Name:	Signature:

## ACCIDENT DETAILS

Describe the accident and how it happened?

Describe your injury?

When did your accident occur?

Date:    /    /                      Time:                      am/pm

Please provide the address of where the injury occurred?

State the name of a witness to the injury:

Address of Witness:

Person to whom accident/incident reported?

Date and time reported?

Date:    /    /                      Time:                      am/pm

Brief summary of treatment/action taken at the time of the accident/incident?

Was hospitalisation required?

If yes, please advise the name of hospital?

If admitted into hospital, how long were you there?

Name of person who gave treatment?

Do you have Private Health Insurance?

If yes, please give fund name?

Advise when you did (or expect to):

Cease work/normal activities \_\_\_\_\_  
 Cease training \_\_\_\_\_  
 Cease participating \_\_\_\_\_  
 Resume work/normal activities \_\_\_\_\_  
 Resume training \_\_\_\_\_  
 Resume participating \_\_\_\_\_

Have you ever had this injury or similar injuries in the past?

If yes, please advise when?

/ /

Please tick the category applicable

Player (    )  
 Official (    )  
 Coach (    )  
 Other (    )

Was your activity at the time of the accident?  
 (please tick)

Officially organised competition (    )  
 Officially organised practice (    )  
 Social or private competition (    )  
 Travelling to and from activity (    )  
 Sanctioned fundraising/social event (    )

## LOSS OF INCOME

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(please tick the box)	Yes	No
1. Can compensation be claimed under worker's compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in 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.**

Name of employer:	Telephone Number: ( )	Fax Number: ( )
Address of employer:		State Postcode
Date ceased work due to injury: / /	Date expected to resume normal duties: / /	
Employee weekly salary as at date of injury: Net \$..... Gross \$..... <small>(If self employed, provide average weekly salary based on 12 month period directly prior to injury).</small>	Date commenced employment with company: / /	
Income Definition:		
* Self Employed	* Full Time	* Part Time * Casual
During the period of incapacity the employee has received		
\$..... Normal Pay	From ..../...../.....	to ..../...../.....
\$..... Sick Pay	From ..../...../.....	to ..../...../.....
\$..... Workers' Compensation	From ..../...../.....	to ..../...../.....
\$..... Other (please specify)	From ..../...../.....	to ..../...../.....
Has the employee returned to work?	* Yes	* No
Has the employee lodged or intending to lodge a Workers Compensation Claim?	* Yes	* No

### A. IF EMPLOYED

Salary officers name:	Phone Number: ( )
Salary officers signature:	Date: / / ABN/ACN:

### B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature:	Date: / /



Office use only  
 Claim Number:.....

**Willis Australia Limited**  
 ABN 90 000 321 237 AFS 240600



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 or  
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 Fax (02) 9283 5276  
 Email: [sports.au@willis.com](mailto:sports.au@willis.com)  
 Website: [www.willis.com.au](http://www.willis.com.au)

## SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

### DOCTOR'S STATEMENT

(PLEASE PRINT LEGIBLY)

#### IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist)
3. If "Yes" answered to any of the following, please give details.
4. Dashes or blank spaces are not acceptable.

### TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Full Name:

How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?

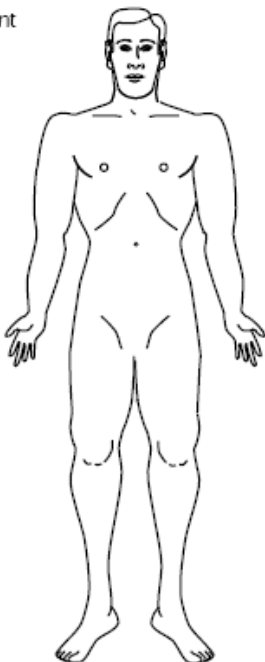
/ /

Are you the patient's regular general practitioner? \* Yes \* No

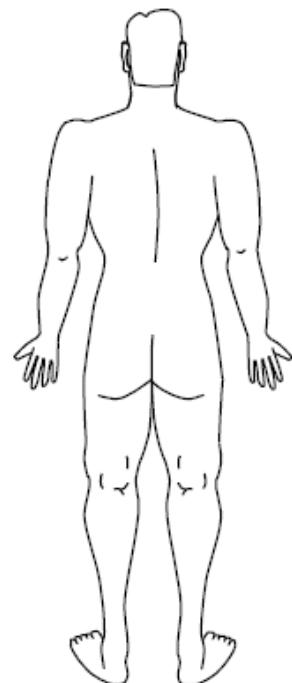
If not, please advise who is .....

What is the exact nature of the present injury?

Front



Back



Head

