

JLT Sport



PO Box 7170 Hutt Street SA 5000
Telephone: 1800 640 009
Facsimile: (08) 8235 6450

Cricket Claim Form

Non Medicare Cover and/or Loss of Income

IMPORTANT INFORMATION: PLEASE READ CAREFULLY

Non Medicare Cover: We do not provide cover 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).

We 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.

- Medical treatment must be certified necessary by the attending Physician, ie. Doctor, Surgeon, Physiotherapist, Dental Surgeon.
- Failure to complete all sections of this form properly may delay settlement of your claim.
- Please refer to your Club or JLT Sport for Benefits, Excess and Special Conditions/Exclusions.
- Please endeavour to submit your claim form as soon as possible. Undue delay may affect your claim settlement.
- Please send 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.
- Only one claim form (per injury) is required. We will advise you of your claim number which should be quoted with all future correspondence.

HOW TO CLAIM MEDICAL ONLY CLAIMS

When claiming for reimbursement of Non Medicare medical expenses you must complete Section A and have Section B completed and signed by your club official. Medical treatment must be certified necessary by AN ATTENDING PHYSICIAN and incurred within Australia. THE ATTENDING PHYSICIANS REPORT MUST BE FULLY COMPLETED PRIOR TO SUBMITTING A CLAIM. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist.)

CLAIMS INVOLVING LOSS OF INCOME

- (a) If claiming for Loss of Income Benefit you must complete Section A and B, and have Section C completed by your Employer;
- (b) Have your Attending Physician complete the "Attending Physicians Report" as attached;
- (c) Have a Doctor complete the "Incapacity to Work Statement". (This **MUST** be completed by a General Practitioner, a Surgeon or a Specialist). It will **NOT** be accepted if completed by a Physiotherapist, Chiropractor etc.)

SECTION A. To Be Completed By The Player
PLEASE PRINT - if there is insufficient space to answer a question, please attach additional sheets.

1. PLAYER'S SURNAME GIVEN NAME _____ SEX: _____		NAME OF CLUB NAME OF ASSOCIATION/LEAGUE	
2. ADDRESS _____		STATE _____	POSTCODE _____
3. DATE OF BIRTH / /	4. OCCUPATION	TELEPHONE HOME ()	WORK ()
4. DATE OF INJURY:/...../.....		TIME OF INJURY: am/pm	
5. DESCRIBE YOUR INJURY & HOW IT HAPPENED?			
6. a. PLAYING SURFACES: INDOOR <input type="checkbox"/> TURF <input type="checkbox"/> SYNTHETIC <input type="checkbox"/> MATTING <input type="checkbox"/> OTHER <input type="checkbox"/>		e. PLAYING POSITION AT TIME OF INJURY <input type="checkbox"/> Fielding <input type="checkbox"/> Batting <input type="checkbox"/> Wicket Keeping <input type="checkbox"/> Bowling <input type="checkbox"/> Umpiring <input type="checkbox"/> Other	
b. WEATHER CONDITIONS: DRY <input type="checkbox"/> WET <input type="checkbox"/>		f. UNDER WHAT CIRCUMSTANCES? <input type="checkbox"/> Officially organised competition <input type="checkbox"/> Officially organised practice <input type="checkbox"/> Social or private competition <input type="checkbox"/> Social or private practice <input type="checkbox"/> Travelling <input type="checkbox"/> Other (Please state what you were doing)	
c. STATE THE NAME OF A WITNESS TO THE INJURY:		g. CRICKET GRADE	
d. PERSON TO WHOM INCIDENT REPORTED:	
DATE...../...../..... TIME REPORTED..... AM/PM			

7. DID YOU CEASE TRAINING / PLAYING IMMEDIATELY AS A RESULT OF THE INJURY? YES NO

If no, please provide reason.
.....

8. WHEN DO YOU EXPECT TO RESUME

WORK: TRAINING: PLAYING:

This section MUST be completed, if exact dates not known please provide approximate dates.

9. WHEN DID YOU FIRST SEEK MEDICAL TREATMENT?...../...../.....

WERE YOU ADMITTED TO HOSPITAL? YES NO If yes, please provide:

HOSPITAL NAME:ADDRESS:

ADMITTANCE DATE:/...../..... DISCHARGE DATE:/...../.....

10. HAVE YOU HAD A SIMILAR INJURY BEFORE TREATMENT YES NO

If yes, please provide details of injury:

.....
.....

DATE WHEN OCCURRED/...../.....

NAME & ADDRESS OF TREATING DOCTOR

11A. DO YOU HAVE PRIVATE MEDICAL INSURANCE? YES NO

NAME OF FUND

DOES YOUR COVER INCLUDE:

i.	HOSPITAL COSTS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ii.	DENTAL AND PHYSIO COSTS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
iii.	AMBULANCE	YES <input type="checkbox"/>	NO <input type="checkbox"/>

B. ARE YOU A MEMBER OF THE AMBULANCE SERVICE YES NO

Signature of Claimant

I hereby 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, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a Photostat/electronic 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 and I agree that if I have made, or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the claim shall be void and all rights to recover there under in respect of past or future injuries or sickness by me shall be forfeited.

In accordance with the Insurance (Agents and Brokers) Act 1984 JLT Sport gives notice that in dealing with or settling this claim they will be acting under an authority given to them by the insurer named in the Certificate of Insurance and that they will be dealing with or settling the claim as agent of the named insurer and not as an agent of the insured.

SIGNED:
(Claimant)

DATED:

SECTION B. TO BE COMPLETED BY YOUR CLUB / ASSOCIATION

DECLARATION (Please advise the claimant of the Policy coverage as per your Schedule of Insurance)

I, of
 (OFFICIAL) (NAME OF CLUB/ASSOCIATION)

Hereby Certify that sustained the injuries resulting in this claim on...../...../.....
 (Player's Name) (Date)

Atam/pm whilst playing / training foragainst
 Place of Game:

Signed: Dated:/...../.....
 (Official)

Official's Position at Club/Association: Contact Phone Number:

SECTION C. LOSS OF INCOME

1. Can compensation be claimed under worker's compensation or any other insurance including Loss of Income?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever made any previous claims in respect to personal accident insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you engaged in any other income earning employment since you have been injured?	Yes <input type="checkbox"/> No <input type="checkbox"/>

The following section must be completed by your employer/salary officer (not player). If self employed, please have your accountant complete these details.

NAME OF EMPLOYER				
ADDRESS OF EMPLOYER		PHONE (.....)		
.....		FACSIMILE (.....)		
.....			
DATE CEASED WORK DUE TO INJURY		DATE EXPECTED TO RESUME NORMAL DUTIES		
EMPLOYEE WEEKLY SALARY AS AT DATE OF INJURY		DATE COMMENCED EMPLOYMENT		
NET \$.....GROSS \$		WITH COMPANY		
(If self employed, provide average weekly salary based on 12 month period directly prior to injury)			
INCOME DEFINITION:	Self Employed <input type="checkbox"/>	Full Time <input type="checkbox"/>	Part Time <input type="checkbox"/>	Casual <input type="checkbox"/>
During the period of incapacity has the employee received a salary? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If Yes: \$..... Period..... to				
Net of business expenses, personal deductions and income tax; excludes bonuses, commissions, and other allowances; and excluding income derived from playing sport.				
A. (If employed) SALARY OFFICER'S NAME..... PHONE NUMBER.....				
(If employed) SALARY OFFICER'S SIGNATURE..... DATE.....				
ABN/ACN				
B. (If self employed) ACCOUNTANT'S NAME.....PHONE NUMBER.....				
(If self employed) ACCOUNTANT'S SIGNATURE.....DATE.....				
ACCOUNTANT'S STAMP				

**All questions relating to this claim must be completed.
 Failure to complete all relevant sections will cause delays in the settlement of the claim**

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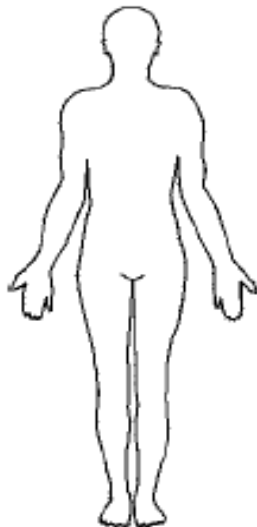
SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

Surname:
Given Names:
Injury Date:

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

1. Diagnosis / History of Injury:
.....
.....



- Concussion
- Cut or Abrasion
- Dislocation
- Fracture
- Twist
- Sprain
- Strain
- Impact Contusion
- Other
Please Specify

2. When did the patient first receive medical attention for the above?/...../.....
By Whom?
Name:
Address:
..... PostCode:

(Continued: See over.)

3. Do you consider the Patient's injury to be a new injury? Yes No
 Recurrence of an old injury? Yes No
 If recurrence please give details and describe:

4. Does the patient have any congenital defects or chronic diseases? Yes No
 If yes, please give dates, name of treating doctor and describe:

5. Have you referred the patient to any other services or treatment?
 Please specify the approximate number of treatments required:
 Physiotherapy
 Chiropractic
 Surgery (Please specify details)
 Other

6. Has the patient been able to do any work since the injury? Yes No

7. What date do you advise the patient to return to Cricket, training/...../..... playing/...../.....

8. SIGNATURE OF TREATING PHYSICIAN: Date:...../...../.....

** If You have been unable to work as a result of the injury, and you are wishing to claim for Loss of Income please arrange for the following to be completed :-

INCAPACITY TO WORK STATEMENT
 (TO BE COMPLETED IF CLAIMING FOR LOSS OF INCOME. IF CONTINUING, A NEW STATEMENT MUST BE FORWARDED FOR EACH PERIOD ABSENT FROM EMPLOYMENT)

CERTIFICATION BY GENERAL PRACTITIONER, SURGEON, SPECIALIST
 I examined the person named overleaf on...../...../.....
 In my opinion this person is/has been unfit for work from/...../..... To/...../..... inclusive.
 Are there any further remarks or comments you can make to assist in assessing this condition?

 DOCTOR'S NAME.....
 ADDRESS.....

 Postcode:
 Telephone Number (.....)..... Facsimile (.....).....
 DOCTOR'S SIGNATURE DATED/...../.....



JARDINE LLOYD THOMPSON PTY LTD

ABN 69 009 098 864

COLLECTION STATEMENT UNDER PRIVACY ACT 1988

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) 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 JLT products or services. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 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 JLT related Group companies.
- By providing the information requested in the attached document, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application or provide other required services, your application for insurance may be declined or you may prejudice your insurance cover.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided, as they occur.
- 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 1988, you must obtain it with the individual's consent.
- Our Privacy Policy can be made available on request or can be accessed on our website (www.jlta.com.au).
- For further information contact your account executive or the JLT Privacy Officer:

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