



AUSTRALIAN WATER POLO SPORTS INJURY INSURANCE CLAIM FORM

This policy is underwritten by Accident & Health International. The issue or acceptance of this form is not construed as an admission of liability on the part of the Company.

Please print clearly. To avoid delays please ensure all relevant sections are completed.

SECTION ONE: COMPULSORY SECTION

Personal Details

Policy Number 0019427

Association/Team Name: _____

Type of Sport or Activity: _____

Claimant's Name: _____ Date of Birth: ____/____/____

Parent / Legal Guardian's Name: _____

Postal Address: _____ Postcode: _____

Daytime Telephone Number: _____ Mobile: _____

Email: _____

What are you claiming for? Medical Expenses / Weekly Benefits (if insured) / Other _____

Please tick preferred form of payment for refund

Cheque: Please nominate payee _____

Direct Payment: Please supply the following information: Account Name _____

Branch Number _____ Account Number _____

Details of Injury

Date and Time of injury: _____

What is the injury? _____

Location where injury occurred: _____

How did the injury occur? _____

Was this an authorised sporting or association activity? Yes / No

Medical Questions

When did you first see a doctor for this condition? Date: ____/____/____

Have you previously suffered from the same or a similar injury? Yes / No Date: ____/____/____

Are there or do you envisage any complications? Yes / No Give details: _____

Do you have other private health cover? Yes / No Type of Cover: _____

Please note that if you have private health insurance you must first make a claim on them.

Name & Phone number of initial Medical Attendant _____

Name & Phone number of your regular Medical Attendant _____

Is there anything in your medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard your recovery? Yes / No Give Details

Nature of operation / hospitalisation (if any) _____ Dates: ____/____/____ to ____/____/____

If you are unable to go to school or work, when do you expect to be able to return? Date: ____/____/____

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SECTION TWO: COMPLETE ONLY IF CLAIMING FOR LOSS OF INCOME (If Applicable)

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

1. IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX

Confirmation of earnings MUST be submitted with claim form (i.e Income Tax Return / Profit & Loss Statement)

2. IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER (Or Attach Pay Slip)

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an injury suffered whilst _____ on the ____/____/____

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was _____ p.w.

Has been employed since ____/____/____

Name of Company _____

Address _____

Signature of Supervisor or Paymaster _____ Name (Please Print) _____

Telephone Number _____ Date ____/____/____

SECTION THREE: COMPULSORY SECTION – CLUB/ASSOCIATION DECLARATION

I certify that _____ was injured on ____/____/____ whilst participating/playing in an authorized club activity.

Name of Club/Association: _____

Name of Secretary/Officer Bearer: _____

Telephone Number: _____

Signature: _____ Date: ____/____/____

SECTION FOUR: COMPULSORY SECTION – DECLARATION AND MEDICAL AUTHORITY

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd underwrite this cover an agent for Allianz Australia Insurance Limited who is a signatory to the General Insurance Code of Practice developed by the Insurance Council of Australia. If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd staff you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days. If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme. Access to the Dispute Resolution scheme is free of charge to you.

Declarations and Authority

Privacy: The Privacy Act 1988 requires us to tell you that on behalf of the Insurer we collect your personal information and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims. When handling claims we may have to disclose and obtain your personal and other information to and from third parties such as other insurers, reinsurers, loss adjusters, medical attendants, external claims data collectors, investigators and agents, to the Insurance Reference Services (IRS), or other parties as required by law. You have the right to seek access to your personal information and to correct it at any time. Please contact Accident & Health and advise us of the changes.

Authority: I authorise any doctor or medical attendant who has treated me or examined me or any person or organisation that employs or has employed me or any other person or organisation who has or may have information regarding my illness/injury to give the underwriter any information it requires to assist in the proof and settlement of my claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Declaration: I/We certify that the information given in this form is truthful accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/We have read and understood the Privacy Act 1998 information and Medical Authority referred to above and consent to the collection, storage and use and disclosure of my/our personal and sensitive information. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Accident & Health will be unable to process my/our claim.

(Please circle) Claimant / Parent / Legal Guardian's Signature: _____

Date: ____/____/____ Print Name: _____

Please note we are unable to process any claim without a signed declaration.

ATTENDING PHYSICIANS STATEMENT

**THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM
WITHOUT EXPENSE TO THE COMPANY**

SECTION FOUR: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME

1. Patient's Name
2. Please give complete diagnosis of this condition

HISTORY

1. When did the patient first receive medical treatment? / /
2. a) Is there a previous history of this or a similar condition? Yes No
- b) If Yes, please provide details
3. a) How long have you known the patient?
- b) Are you the regular general practitioner?
- If not, please advise who is

INJURY / SICKNESS

1. When did the patient first suffer the injury?
2. What was the cause of the injury?
- OR**
3. When was sickness first contracted? / / When did symptoms become evident? / /

DEGREE OF DISABILITY

1. When was patient obliged to cease work?
2. When was/will the patient be/able to return to:
- a) Some duties? / / OR b) Full duties? / /

TREATMENT OF PRESENT CONDITION

- When were you consulted? a) Initially / / b) Most recently / /
- Was patient confined to hospital? Yes No Period of confinement / / To / /
- If Yes, please advise Name and Address of hospital
- What other surgical or medical procedures are possibly contemplated?
- Are there any underlying conditions affecting recovery from the current conditions? Yes No
- If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery
-
- What is the current prognosis?
- Are there any further remarks which may assist in assessing this condition?

Date Signature Qualification

Name (Please print) Address

City or Town State Telephone

**NON-MEDICARE MEDICAL EXPENSES
NOTICE TO CLAIMANTS**

If you are claiming reimbursement for expenses incurred as a direct result of injury, please complete the following claim schedule. If you are claiming the difference or shortfall of a payment from Accident & Health, you must first seek reimbursement from your Private Health fund (if applicable) and submit the accounts with your claim. For reimbursement relating to Medical Expenses, please read the following information carefully:

We advise that Your Policy will cover non-Medicare Medical Expenses to the amount stated in the Policy (after the deduction of any excess) for injuries which occur during insured activities. The policy will cover fees incurred as a result of injury including, but not limited to fees paid to nurses, chemists, hospitals, chiropractors, osteopaths and physiotherapists. Please note that you are expected to settle accounts first and then seek reimbursement.

We advise that this company must comply with Federal legislation that limits the benefits that General Insurers, Health Funds (and others) are legally allowed to insure. As a General Insurer we are *prohibited* from reimbursing medical expenses that are covered by the Medicare Scheme.

We can pay:

- ✓ 100% of Theatre Fees & Accommodation Fees in a hospital where the Insured Person is a *private* patient in a public or private hospital.
- ✓ Any other medical expenses which are not covered by Medicare.

We cannot pay:

- * Any *out of hospital or outpatient* expenses which have a Medicare component.
- * Any amounts above the Scheduled Fee, or “gap” fees related to Medicare services
- * When you are a *public* patient in a private or public hospital. Everything is covered by Medicare in this circumstance.
- * Specifically, for out of hospital physician or specialist Doctor visits, Medicare refunds 85% of the Scheduled Fee. No-one can reimburse any other amount for these expenses.

Examples

Medical Service	Amount Charged	Scheduled Fee	Medicare Pays	We Pay	Insured Pays
Private Hospital Accommodation	\$400.00	\$0.00	\$0.00	\$400.00	\$0.00
Hospital Doctor Consultation	\$92.00	\$62.85	\$53.45	\$0.00	\$38.55
GP Consultation out of hospital (no bulk billing)	\$36.00	\$24.50	\$20.85	\$0.00	\$15.15

Please note that where a Private Health Fund has reimbursed the “gap, no further reimbursement is available.

Further information on these limitations should be available from the Health Insurance Commission.



SECTION FIVE: ACCIDENT / INJURY EXPENSE CLAIM FORM

Date Expense Incurred	Item Description	A	B	C	D	Office Use Only	
		Fee Charged	Scheduled Fee	Medicare Benefit	Health Fund Benefit	Amount Payable By A&HI	Details
Totals:							

Reimbursement is calculated as follows:

A – D in the case of no Medicare component

Please note that Federal Legislation prohibits General Insurers from contributing to out of pocket expenses against Medicare eligible services.

Please note that in the case of a “Medicare gap” being paid by your Health Fund, no further benefit is claimable from Accident & Health International.