Marsh Personal Injury Claim Form

AusCycling National Insurance Program

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- ✓ **You are an Insured person –** AusCycling Member, official, coach and or volunteer; and
- ✓ **You have sustained an injury –** whilst participating in a cycling activity/event; and
- ✓ **You have incurred costs –** Non-Medicare medical costs

Before completing this form, please read the Product Disclosure Statement (PDS) on our website https://au.marsh.com/sport.html

WHAT IS COVERED?

Non-Medicare Medical Costs
Loss of Income
Death & other Capital Benefits
Commonwealth Legislation prevent reimbursement of Medicare costs including the Gap.

HOW MUCH CAN I CLAIM?

Non-Medicare Medical Costs	**Loss of Income**
85% Reimbursement	85% Reimbursement
$7,500 maximum per claim	$500 maximum per week
$75 excess per claim	28 day elimination period

HOW TO LODGE A PERSONAL INJURY CLAIM:

1. Complete ALL sections of this form
2. Send your completed form to Marsh as soon as possible
3. Marsh will lodge this with the insurer who will confirm receipt of your claim
4. Any further costs can be submitted to the insurer by quoting the claim number provided
5. Documents can be submitted by email, post or fax

HOW TO SEND COMPLETED FORMS

Email:	Sport@Marsh.com	
Post:	Marsh Pty Ltd – 727 Collins Street, Melbourne, VIC 3008	
Phone No:	1300 130 393	

IMPORTANT INFORMATION

- You can't claim for any services where you receive a rebate from Medicare
- We recommend you retain a copy of all receipts and your claim form for your records
- Claim through your Private Health Fund first, where possible

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SECTION A – CLAIMANT'S DETAILS					
PERSONAL INFORMATION					
Claimant's Name:					
Address:					
State:		Postcode:			
Occupation:					
Phone Number:					
Email Address:					
Date of Birth:			Gender:	☐ Male	☐ Female
Date of Injury:		Time of Injury:		☐ AM	☐ PM
Describe your injury and how it happened (please attach additional pages if required):					

INJURY RESEARCH DATA	
Circumstances:	
☐ Competing on a Track	☐ Riding on Public Road in a Bunch (Less than 6)
☐ Riding Solo on Public Road	☐ Riding on Public Road in a Bunch (6 or more)
☐ Competing on Closed Circuit	☐ Racing on MTB Trail
☐ Training on Close Circuit	☐ Racing / Training under a UCI License
☐ Riding on Bike Path	☐ Riding on MTB Trail
☐ Other	
Club or Recreation: At the time of your accident were you involved in?	
☐ A direct club organized activity or;	
☐ Your own personally organized activity	
☐ A direct private promoter ride.	

Injured person:	☐ Rider	☐ Judge	☐ Official	☐ Coach	☐ Other
Grade:	☐ Senior	☐ Junior	☐ Not applicable		

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Resumption date(s):					
When will you resume WORK?					
Do you have Private Health Insurance?				☐ YES	☐ NO
If YES, what is the name of your Private Health Insurance Provider?					
Private Health Coverage:	☐ Dental	☐ Physiotherapy	☐ Ambulance	☐ Hospital	
Ambulance Membership:				☐ YES	☐ NO

PAYMENT DETAILS

EFT Payee Details:

Bank:		Name Account Held In:	
BSB:		Account Number:	

CLAIMANT DECLARATION

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

A. The injury was sustained accidentally during Cycling activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at au.marsh.com/sport

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing coststhat are registered with Medicare (including the Medicare Gap).

D. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of MARSH, the insurer, the Trustee and the Claims Managers.

E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish MARSH's representatives with 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 employment records.

F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

G. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.

H. You authorise any and all information regarding claims with any other insurer to be released to MARSH's representatives.

Claimant's Signature* (**Parent or Guardian if under 18 years)*	
Date:	

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SECTION C – LOSS OF INCOME		
TO BE COMPLETED BY THE CLAIMANT		
Do you wish to claim Loss of Income Benefits? **If No, please proceed to SECTION D**	☐ YES	☐ NO
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 policyor plan?	☐ YES	☐ NO
Have you engaged in any other income earning employment since you became injured?	☐ YES	☐ NO

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)				
Claimant's Name:				
Employer/Company Name:				
Contact Person:				
Postal Address:				
State:		Postcode:		
Email Address:				
Phone: (Bus. Hours)		Mobile:		
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed
EMPLOYMENT DETAILS				
Employee's NET weekly salary			$	
Employee's GROSS week salary			$	
Date Employee commenced with company.				
IF SELF-EMPLOYED OR CASUAL, PLEASE PROVIDE AVERAGE WEEKLY SALARY BASED ON 12 MONTH PERIOD DIRECTLY PRIOR TO INJURY.				
INJURY DETAILS				
Date employee ceased work:				
Date expected to resume duties:				
RETURNED TO WORK				
Has the Employee returned to work?			☐ YES	☐ NO
If YES, what date did the Employee return?				
SALARY RECEIVED				
During the period of incapacity, has the employee received a salary?			☐ YES	☐ NO
If YES, what for?				

Sick Leave:	☐ YES	☐ NO	From:		To:	
Annual Leave:	☐ YES	☐ NO	From:		To:	
Other:	☐ YES	☐ NO	From:		To:	

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances.Excludes income derived from playing sport.

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EMPLOYER'S DECLARATION:	
By signing the declaration below, you confirm and agree to the following: A. You are the Claimant's current employer (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 Signature: ** Accountant's signature (if claimant is self-employed)*	
Date:	

For more information, please refer to MARSH's website: au.marsh.com/sport.html
This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH

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SECTION D – PHYSICIAN'S REPORT

PHYSICIAN'S REPORT

This section must be completed (in full) by your attending physician. An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

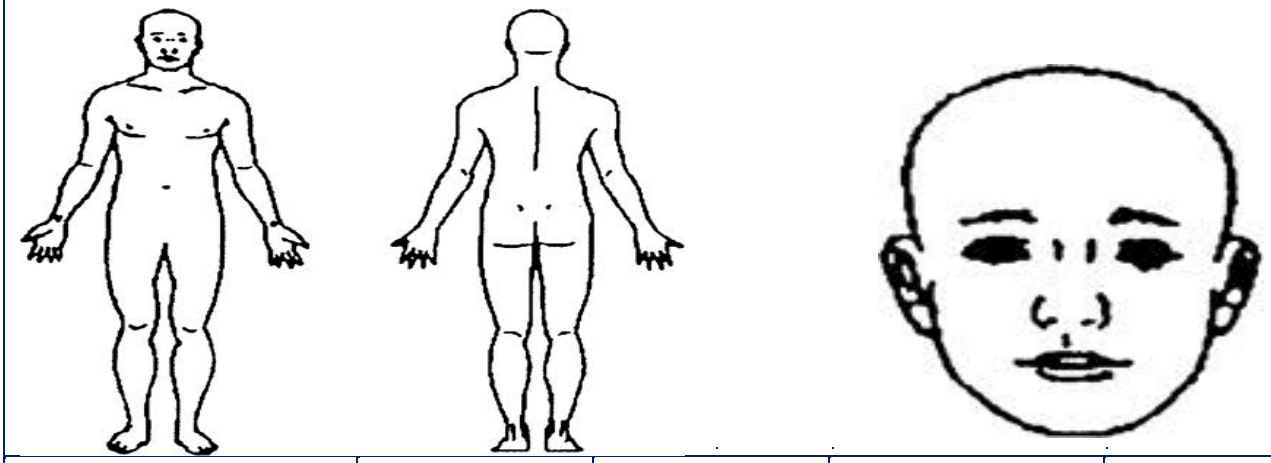
THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH

Claimant's Name:			
Physician's Name:			
Phone Number:			
Date of Injury:		Date of Consultation:	

Diagnosis/History of injury:

Injury Location:	☐ Ankle	☐ Arm	☐ Dental	☐ Facial	☐ Foot
	☐ Hand	☐ Head	☐ Internal	☐ Knee	☐ Lower Leg
	☐ Shoulder	☐ Spinal	☐ Torso	☐ Upper Leg	

Please mark (x) the anatomical location below:



Injury Type:	☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Death
	☐ Rupture	☐ Sprain	☐ Strain	☐ Fatigue/Debilitation

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:		
Does the Claimant have any congenital defects or chronic diseases?	☐ YES	☐ NO
If YES, please provide details and a description (dates, name of treating doctor, etc):		
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.		
Chiropractic:	☐ YES	☐ NO
If YES, approx. number of treatments required.		
Surgery:	☐ YES	☐ NO
If YES, please provide details		
Other:	☐ YES	☐ NO
If YES, please provide details		
Has the Claimant been able to do any work since the injury occurred?	☐ YES	☐ NO
What date do you advise the Claimant to return to playing Cycling?		

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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.

Physician'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, _____ (Medical Practitioner's Name) examined _____ (Claimant's Name) on _____ (Date of examination)

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

Please provide any further comments in regard to your assessment of the injury/condition?

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.

Medical Practitioner's Signature:	
Date:	

DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty of disclosure under the Insurance Contracts Act 1984 (Cth) to tell us anything that you know, or could reasonably be expected to know, may affect the insurer's decision to insure you and on what terms. You have this duty until the contract of insurance is entered into. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

If we ask you questions that are relevant to the insurer's decision to insure you and on what terms, you must tell us anything that you know and that a reasonable person in the circumstances would include in answering the questions. Also, we may give you a copy of anything you have previously told us and ask you to tell us if it has changed. If we do this, you must tell us about any change or tell us that there is no change. If you do not tell us about a change to something you have previously told us, you will be taken to have told us that there is no change.

You do not need to tell us anything that: reduces the risk insured, or is common knowledge, or the insurer knows or should know as an insurer; or the insurer waives your duty to tell them about.

If you do not tell us something:

If you do not tell us anything you are required to, the insurer may cancel your contract or reduce the amount it will pay you if you make a claim, or both. If your failure to tell us is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

If you are in any doubt as to the extent of the duty of disclosure or whether a piece of information ought to be disclosed, just contact your Marsh Client Risk Adviser.

MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Marsh Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Marsh') 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 Marsh products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984 (Cth), the Marine Insurance Act 1909 (Cth) 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 Marsh's Associated Entities, which are all businesses of Marsh & McLennan group of companies ('MMC').
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other MMC companies, insurers, reinsurers and other third party service providers (e.g. data storage providers) in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.
- 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, you must obtain it with the individual's consent.
- We will use and disclose your personal information in accordance with our Privacy Policy. By completing this form you confirm that you have read the Marsh Privacy Policy available on our website (www.marsh.com.au) and you authorise and consent to Marsh collecting, holding, using and disclosing any personal information collected by means of the enclosed document in accordance with the terms of the Marsh Privacy Policy, including for the purposes explained in this collection statement above. If there are any inconsistencies between the terms of this collection statement and the terms of the Marsh Privacy Policy, the terms of the Marsh Privacy Policy prevail to the extent of that inconsistency. You may modify or withdraw your consent at any time. If you do not give us consent or subsequently modify or withdraw your consent, we may not be able to provide you with the products or services you want.
- You can contact our Privacy Officer by:

  Email – privacy.australia@marsh.com

  Phone – (02) 8864 7688

  Post – PO Box H176, Australia Square NSW 1215

The advice in this form is general advice only. To help you decide if the cover suits you, please read the Product Disclosure Statement. We can provide you with further information. Please contact us to request. This insurance is arranged by Marsh Advantage Insurance Pty Ltd (ABN 31 081 358 303, AFSL 238 369) ('MAI'). MAI are not the insurer.