2009 AUSTRALIAN FOOTBALL NATIONAL RISK PROTECTION PROGRAMME

PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

NON-MEDICARE MEDICAL AND LOSS OF INCOME CLAIMS ONLY

For Policy Wordings, Summary of Cover and other information relating to Personal Injury claims, please refer to:

www.jltsport.com.au/afl

Claims Enquiries:
1800 640 009

Please send your completed claim form and attachments to:

Echelon Claims Services PO Box 7170, Hutt Street, SA 5000	OR	Fax: (08) 8235 6450

General Enquiries:
1300 130 373

HOW TO LODGE A PERSONAL INJURY CLAIM:

Step 1: **Access a *current* claim form via www.jltsport.com.au/afl or call Echelon on 1800 640 009**

Step 2: **Complete *all* relevant sections of the claim form.**
- Your claim form may be returned if there is important information missing
- For assistance contact Echelon on 1800 640 009

Step 3: **Send your claim form to Echelon *as soon as possible* (within *180 days)* from the date of injury.**
- If treatment of the injury is likely to continue beyond 180 days, please send through your claim form with any current receipts received and contact Echelon for further assistance.

Step 4: **Echelon will confirm receipt of your claim or make contact with you should they require more information.**
- Please contact Echelon directly if you have not received confirmation of your claim within 2 weeks from the date of lodgement.

IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS: *Please read the following information carefully*

Who is Echelon?
Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of Jardine Lloyd Thompson Pty Ltd. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the National Risk Protection Program.

We legally can not reimburse you for Medicare-related costs:
The Health Insurance Act (Cth) 1973 does not permit the Insurer or the Trustee to reimburse you for any costs associated with medical treatments registered with Medicare (this includes the Medicare Gap).

Only Non-Medicare Medical Treatments can be reimbursed (as per the Policy Wording):
- All treatments must be certified as “necessary” by your physician. i.e. Doctor, physiotherapist, etc
- Please refer to JLT Sport’s web site (www.jltsport.com.au/afl) for benefits, excesses and special conditions/exclusions

Attach Original Receipts:
- Send original receipts with your claim form (unless retained by your private health fund).

If you have Private Health Cover:
- Claim on your private health fund first and attach a copy of their rebate advice to this form.

Privacy of your personal details:
- We collect, store and use your personal details in-line with the Privacy Act (Cth) 1988. For a copy of our Privacy Statement please contact JLT Sport on 1300 130 373 or view it online www.jltsport.com.au

Examples of items covered by Medicare.
We can not reimburse you for these costs.
- Doctor
- Surgeon
- Surgeon’s Assistant
- Anaesthetist
- X-rays
- MRI Scans*
- Public Hospitals

Examples of Non-Medicare items.
Claimable as per the Policy Wording.
- Ambulance
- Physiotherapist
- Dental
- Private Hospital Accommodation
- Chiropractor
- MRI Scans*

PLEASE NOTE:
** MRI scans are generally claimable through Medicare, however please check with your referrer and/or provider to confirm if this is the case prior to lodging your claim.*

CLAIM FORM CHECKLIST: *Please use the checklist below to ensure ALL sections are completed as required.*

SECTION A:	SECTION B:	SECTION C:*	SECTION D:
❑ Claimant’s details	❑ Club declaration	❑ Confirmation of Loss of Income Cover	❑ Injury details
❑ Injury details	❑ Signed by authorised club representative	❑ Employment Details	❑ Signed by your physician
❑ Injury research		❑ Signed by Employer	
❑ Signed by Claimant			

* Section C must be completed only when claiming for Loss of Income. Loss of Income is an OPTIONAL cover. Before lodging your claim, please obtain verification from your club or association/league that you are covered for Loss of Income Benefits in Season 2009.

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CLAIM FORM SECTION A:

THIS SECTION MUST BE COMPLETED IN FULL BY THE CLAIMANT OR A LEGAL GUARDIAN IF THE CLAIMANT IS UNDER 18 YEARS OF AGE.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE SEND YOUR COMPLETED CLAIM FORM AND ORIGINAL RECEIPTS TO:

ECHELON CLAIMS SERVICES, PO BOX 7170, HUTT STREET, SA 5000 | OR FAX: (08) 8235 6450

PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.

1 ______________________ Claimant's Surname

2 ______________________ Claimant's First Name

3 Male / Female Gender

4 ____/____/______ Date of Birth (DD/MM/YYYY)

5 ______________________ Claimant's Personal Mailing Address ________ State ________ Post Code

6 (   ) ______________ Contact Phone Number

7 ______________________ Claimant's Occupation (if applicable)

8 (   ) ______________ Work Phone Number

9 ____/____/______ Date of Injury (DD/MM/YYYY)

10 ________:________am/pm Approx. Time of Injury (HH:MM)

11 ______________________ Club Name

12 ______________________ League/Association Name

13 Describe the injury and how it happened (please use additional pages if required).

14 Describe any other factors that may have contributed to your injury (leave blank if not applicable).

15 Where did the injury occur? ❑ Indoor ❑ Outdoor

16 What was the surface type at the time of injury? ❑ Grass ❑ Indoor surface ❑ Concrete/asphalt ❑ Other____________ Please specify

17 What were the weather conditions? ❑ Fine ❑ Rain ❑ Showers ❑ Extreme heat ❑ Extreme cold ❑ Other____________ Please specify

18 What were the surface conditions? ❑ Wet ❑ Dry ❑ Muddy ❑ Hard

19 What were your circumstances at the time of injury? ❑ Playing ❑ Training ❑ Travelling ❑ Other____________ Please specify

20 In which quarter/period were you injured? ❑ 1st ❑ 2nd ❑ 3rd ❑ 4th

21 How did the injury occur? ❑ Fall ❑ Slip/Trip ❑ Overuse ❑ Other____________ Please specify

22 Please indicate when you intend to resume the following activities. If exact dates are not known, please provide approximates.

________/________/________ ❑ N/A When will you resume WORK?

________/________/________ When will you resume TRAINING?

________/________/________ When will you resume PLAYING?

23 Do you have private health cover? ❑ YES ❑ NO

24 If yes, what is the name of your private health fund? ______________________

25 Please indicate the covers offered by your private health fund ❑ Dental costs ❑ Physiotherapy costs ❑ Ambulance ❑ Hospital costs

26 Are you a member of the Ambulance Service? ❑ Yes ❑ NO

27 Please indicate to whom re-imbursement cheques are to be made payable:

❑ Myself ❑ Other

______________________ Contact Person ______________________ Cheque made payable to

______________________ Address ________ State ________ Post code

I, the undersigned, hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other authorised members of the JLT Sport (Australian Football National Risk Protection Programme) Discretionary Trust Arrangement. I allow this information to be used as part of the Trust's risk management processes and reporting criteria. I 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, treatments, copies of all hospital or medical records and copies of all records of employers. I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the forgoing particulars are true and correct in every detail. I agree that if I have made, or shall make in any further declaration in respect to said injury, any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the covers shall be void and all rights to recover there under in respect to past or future injuries shall be forfeited.

28 **Claimant's signature (or Parent/Guardian if under 18 years)**

________/________/________ **Date**

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CLAIM FORM SECTION B: CLUB/LEAGUE DECLARATION

THIS SECTION MUST BE COMPLETED IN FULL BY AN AUTHORISED CLUB OR LEAGUE REPRESENTATIVE

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE PRINT

I, the undersigned, as authorised representative of ______________________ hereby declare that
Name of Club/League

______________________ sustained the injuries outlined on this claim form on ____/____/______
Name of Claimant — Date of Injury

at ____________ whilst ❑ Playing ❑ Training for ______________________ ❑ Home team ❑ Away team
Time of Injury — Select one — Name of Claimant's Club/Team

at ______________________ against ______________________
Name of Ground/Place of Injury — Name of Opposition Club/Team (if applicable)

I confirm that our club/association/league has completed all registration requirements for the 2009 National Risk Protection Programme, including the compulsory online Risk Management Education Training Module via JLT Sport's Web Site (www.jltsport.com.au/afl).

I confirm that the Claimant
❑ Has not returned to playing/training.
❑ Returned to playing/training on: ________/________/________
Date Claimant returned

This claimant's club/team has the following level of cover for the 2009 National Risk Protection Programme (please answer if known):
❑ Bronze (Standard Cover) ❑ Silver ❑ Gold ❑ Platinum

Loss of Income Cover Details:

I confirm that ______________________
Claimant / Team
❑ Has not purchased Loss of Income Cover for Season 2009.
❑ Has Purchased Loss of Income Cover for Season 2009 as per the details below.

❑ Junior Team ❑ Senior Team ❑ Individual $ __________ Per week ❑ 14 days ❑ 49 days (Excess) _______/_______/_______ Date of Purchase

CLUB/LEAGUE DECLARATION. *This must be signed by an authorised club/league representative. If blank, your claim may be delayed.*

____
Authorised Club/League Representative's name (please print)

____
Authorised Club/League Representative's Title/Position

____
Authorised Club/League Representative's signature

_______/_______/_______
Date

____
Authorised Club/League Representative's contact email

____
Authorised Club/League Representative's contact number

UPGRADING COVER:

Please note, all clubs receive the basic minimum cover of *Bronze* at the commencement of each Policy Period. Clubs may upgrade to a higher level of cover at an additional premium. Upgraded cover is valid only from the date of purchase. For an Upgrade Form and details please visit www.jltsport.com.au/afl. The following table outlines the reimbursement for the various levels of cover within the 2009 National Risk Protection Programme:

	Bronze (Basic Cover)	Silver	Gold	Platinum
Non-Medicare Medical Costs	50% Reimbursement	75% Reimbursement	90% Reimbursement	90% Reimbursement
	$2,000 max. per claim	$2,500 max. per claim	$3,500 max. per claim	$7,500 max. per claim
	$100 excess per claim	$75 excess per claim	$50 excess per claim	$50 excess per claim
Capital Benefits	$100,000 ($20,000 for U18)	$150,000 ($30,000 for U18)	$200,000 ($40,000 for U18)	$250,000 ($50,000 for U18)

* All clubs within the Victorian Country Football League receive Silver cover as the basic minimum cover.

LOSS OF INCOME BENEFITS:

Please note, Loss of Income benefits are not included within the standard cover provided by the National Risk Protection Programme. Clubs/Leagues must purchase this cover for an additional premium as per JLT Sport's Optional Upgrade Procedures (for details please refer to www.jltsport.com.au/afl).

Loss of Income Benefits provide reimbursement for either 80% of the player's net weekly income or the maximum amount per week as purchased by the club/league – whichever is the lesser. Coverage is for a maximum of 52 weeks and a 14 or 49 day elimination period applies (as per the cover purchased). This means that the claimant must lose 14 or 49 days income due to the injury before a claim is payable.

If claiming for Loss of Income Benefits you must complete Section A and Section B of this form, and have Section C completed by your employer. Section D must be completed including the Incapacity to Work Statement completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

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CLAIM FORM SECTION C: LOSS OF INCOME BENEFITS

THIS SECTION MUST BE COMPLETED ONLY IF YOU ARE CLAIMING LOSS OF INCOME BENEFITS.

LOSS OF INCOME IS AN OPTIONAL COVER. PLEASE CHECK WITH YOUR CLUB PRIOR TO COMPLETING THIS SECTION TO ENSURE YOU ARE COVERED FOR LOSS OF INCOME BENEFITS.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.

1 – 6 to be completed by the Claimant.

1 Do you wish to claim for Loss of Income Benefits? ❑ YES ❑ NO *If NO, please proceed to Section D*

2 Has your club purchased Loss of Income Cover on your behalf? ❑ YES ❑ NO *If NO, you may not be eligible for Loss of Income Benefits.*

3 If Yes, what is the Excess Period? ❑ 14 days ❑ 49 days What is the weekly amount? $____________per week

4 Can you claim compensation under Worker's Compensation or any other policy that includes loss of income benefits? ❑ YES ❑ NO

5 Have you ever made any previous claims in respect to a personal accident insurance policy or plan? ❑ YES ❑ NO

6 Have you engaged in any other income earning employment since you became injured? ❑ YES ❑ NO

7 – 20 to be completed by the Employer*.

7 ______________________________ Name of Employer (Business Name)

8 ______________________________ Name of Contact Person

9 ______________________________ Employer's address

______________ State

______________ Post Code

10 ( ) ______________ Employer's Phone Number

11 ( ) ______________ Employer's Facsimile Number

12 ________/_______/___________ Date Employee commenced with the organisation

13 $ ______________ Employee's NET weekly salary as at date of injury

14 $ ______________ Employee's GROSS weekly salary as at date of injury

If self employed, please provide average weekly salary based on 12 month period directly prior to injury.

15 What is the Employee's income definition ❑ Full Time ❑ Part Time ❑ Casual ❑ Self Employed

16 _______/_______/__________ Date Employee ceased work due to injury

17 _______/_______/__________ Date expected to resume normal duties

18 Has the Employee returned to work? ❑ YES ❑ NO If YES, what date? ________/_______/___________

19 During the period of incapacity has the employee received a salary? ❑ YES ❑ NO If YES, What for?

❑ Sick leave Salary received from ______/_______/______ to ________/_______/_______

❑ Annual leave Salary received from ______/_______/______ to ________/_______/_______

❑ Other Salary received from ______/_______/______ to ________/_______/_______

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

20 ______________________________ **If Employed - Salary Officer's Name (please print)**

______________ **Salary Officer's Phone Number**

______________________________ **If Employed - Salary Officer's signature**

_______/_______/_______ **Date**

______________________________ **If SELF EMPLOYED - Accountant's name (please print)**

______________ **Accountant's Phone Number**

______________________________ **If SELF EMPLOYED - Accountant's signature**

_______/_______/_______ **Date**

*Please note: If you are SELF EMPLOYED, please have your Accountant complete this section.

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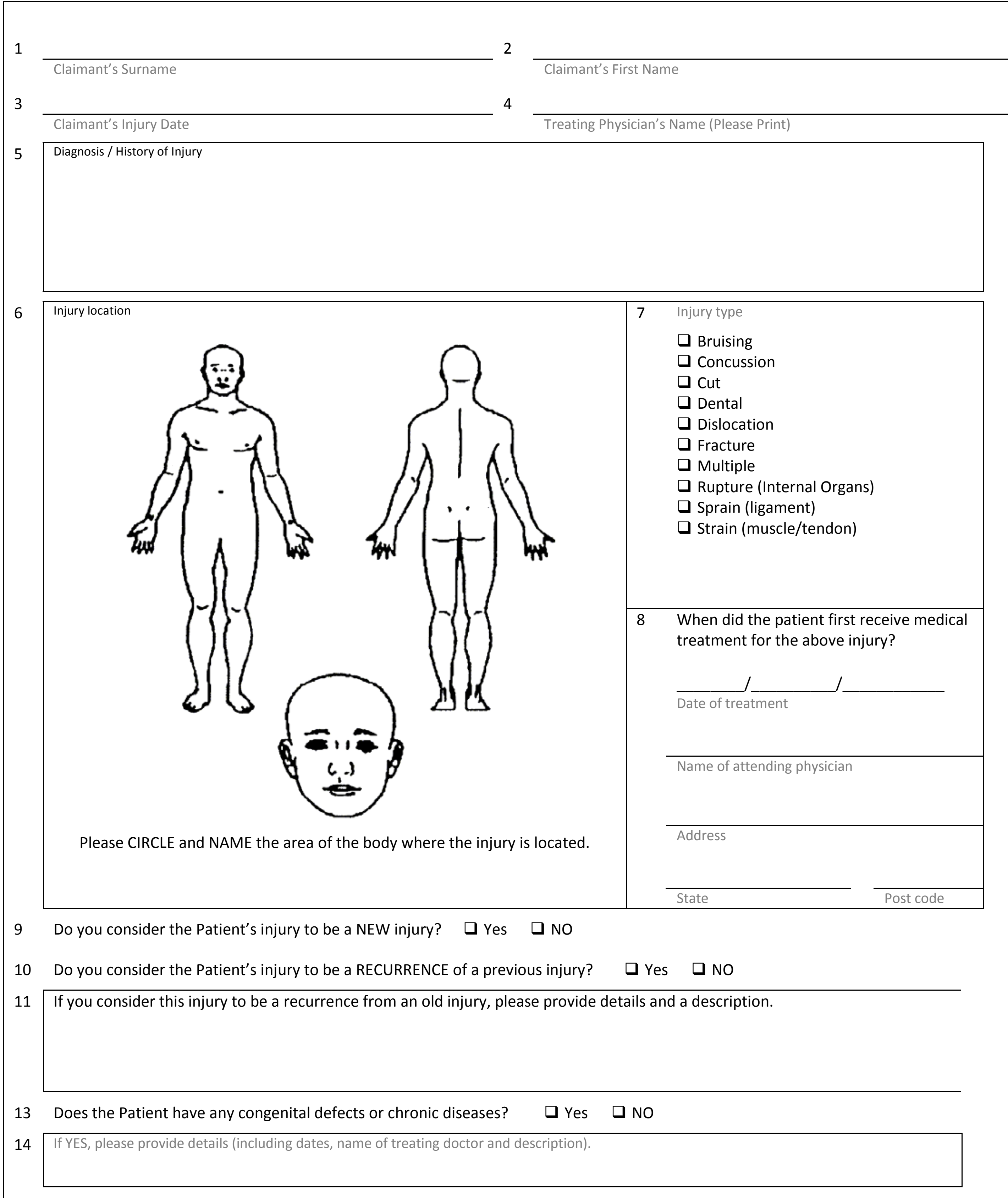
CLAIM FORM SECTION D: PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED IN FULL BY YOUR TREATING PHYSICIAN.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT.

FOR INJURIES SUSTAINED BETWEEN 1ST JANUARY 2009 AND 1ST NOVEMBER 2009

PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.



1 ______________________ Claimant's Surname

2 ______________________ Claimant's First Name

3 ______________________ Claimant's Injury Date

4 ______________________ Treating Physician's Name (Please Print)

5 Diagnosis / History of Injury

6 Injury location

Please CIRCLE and NAME the area of the body where the injury is located.

7 Injury type

- ❑ Bruising
- ❑ Concussion
- ❑ Cut
- ❑ Dental
- ❑ Dislocation
- ❑ Fracture
- ❑ Multiple
- ❑ Rupture (Internal Organs)
- ❑ Sprain (ligament)
- ❑ Strain (muscle/tendon)

8 When did the patient first receive medical treatment for the above injury?

________/__________/____________
Date of treatment

______________________ Name of attending physician

______________________ Address

______________ State ______________ Post code

9 Do you consider the Patient's injury to be a NEW injury? ❑ Yes ❑ NO

10 Do you consider the Patient's injury to be a RECURRENCE of a previous injury? ❑ Yes ❑ NO

11 If you consider this injury to be a recurrence from an old injury, please provide details and a description.

13 Does the Patient have any congenital defects or chronic diseases? ❑ Yes ❑ NO

14 If YES, please provide details (including dates, name of treating doctor and description).

Please continue to page 6.

CLAIM FORM SECTION D: PHYSICIAN'S REPORT (CONTINUED)

15 Have you referred the patient to any other services or treatment? ❑ Yes ❑ NO

16 If YES, please specify the approximate number of treatments required.

❑ Physiotherapy ______________ Treatments required

❑ Chiropractics ______________ Treatments required

❑ Surgery ______________ Treatments required ______________ Please provide surgery details

❑ Other ______________ Treatments required ______________ Please provide details

17 Has the patient been able to do any work since the injury occurred? ❑ Yes ❑ NO

18 What date do you advise the patient to return to playing football? ________/__________/____________ Date advised to return to football

I, the undersigned, declare that I have examined the Claimant's injury as described on this form. I hereby declare that all information I have provided on this form is true and accurate as at the date of examination.

19 ______________ **Physician's name (please print)** ______________ **Physician's Phone Number**

______________ **Physician's signature** ________/________/________ **Date**

Incapacity to Work Statement

Only complete this section if claiming for Loss of Income.

Incapacity to Work Statement must be completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist).
It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

I, ______________ (Medical Practitioner's name) examined ______________ (Claimant's name) on ______/______/______. (Date of Examination)

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

Please provide any further comments/remarks in regard to your assessment of this injury/condition.

______________ **Medical Practitioner's Name** ______________ **Medical Practitioner's Phone Number**

______________ **Medical Practitioner's Address** ______________ **State** ______________ **Post Code**

______________ **Medical Practitioner's Signature** ________/________/________ **Date**