



BASKETBALL AUSTRALIA PERSONAL INJURY CLAIM FORM

IMPORTANT INFORMATION: PLEASE READ CAREFULLY

Non-Medicare Cover: We do not provide cover for Surgeons, Anesthetists, 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 Horsell International for Benefits, Excess and Special Conditions/Exclusions.
- Horsell International are contactable on:-
Phone: (02) 9247 1700
Fax: (02) 9247 1733
Email: sports@horsell.com
Website: www.horsell.com
- 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 PHYSICIAN 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.)

Claims forms are to be sent to AIG:-

American International Group
GPO Box 4363
Melbourne, Victoria 3001
Telephone (03) 9522 4000
Facsimile (03) 9522 4645

SECTION B. TO BE COMPLETED BY THE CLUB

CLUB DECLARATION (please advise the claimant of the Policy coverage as per your Schedule of insurance)	
REFERENCE NO:	
I, of	
Hereby Certify that sustained the injuries resulting in this claim on / / (date)	
At am/pm whilst playing/training for	
against Place of Game	
Signed:..... (club official)	Dated: / /

SECTION C. LOSS OF INCOME

PLEASE NOTE: **THIS IS AN OPTIONAL SECTION. TO CHECK IF THE POLICY INCLUDES THIS COVER PLEASE REFER TO YOUR CLUB OR HORSELL INTERNATIONAL PTY LTD**

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

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 / /	
INCOME DEFINITION:	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Casual
During the period of incapacity has the employee received a salary? <input type="checkbox"/> YES <input type="checkbox"/> NO				
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.....				
SALARY OFFICER'S SIGNATURE				
DATE..... / /				
COMPANY STAMP				



SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

CLAIM NUMBER:

Surname:

Given Names:

Injury Date:

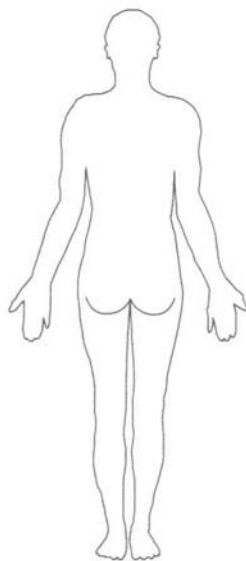
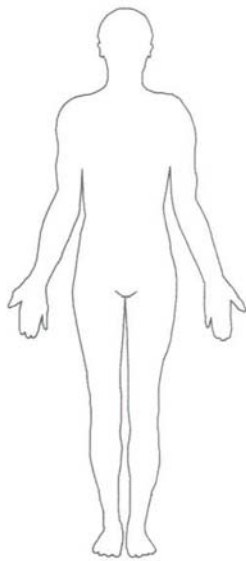
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO HORSELL INTERNATIONAL PTY LTD

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

3.	Do you consider the Patient's injury to be a new injury? <input type="checkbox"/> YES <input type="checkbox"/> NO Recurrence of an old injury? <input type="checkbox"/> YES <input type="checkbox"/> NO If recurrence please give details and describe:
4.	Does the patient have any congenital defects or chronic diseases? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please give dates, name of treating doctor and describe:
5.	Have you referred the patient to any other services or treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO Please specify the approximate number of treatments required: <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Surgery (please specify details <input type="checkbox"/> Other
6.	Has the patient been able to do any work since the injury? <input type="checkbox"/> YES <input type="checkbox"/> NO
7.	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 (and your club's Policy provides this cover) 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:/...../.....