The Australian Veterans Cycling Council Inc.

OAMPS
Insurance Brokers
AN ARTHUR J. GALLAGHER COMPANY

Personal Injury Claim Form

Please complete Parts 1–8 of this claim form (pages 2 and 3), plus the injury data collection questions on pages 5 and 6

1. Ask Your doctor to complete the 'Medical Statement' (pages 7 and 8)
2. If you are covered for loss of earnings and you wish to make a claim in that regard:
   a. Ask Your employer to complete Part 9 (page 4). If You are self-employed please have Your accountant complete these details
   b. Forward a medical certificate every two weeks if Your disability is continuing
3. An authorised official of Your club must complete Part 10 (page 6)
4. Please refer to 'Notes for claimants' on page 9
5. To maximise claims handling efficiency send your completed claim form to the OAMPS office in your nearest capital city. Refer to the bottom of page 9 for office addresses.

1: The State Body

State body:_____

Association name: _____

Club: _____

Age group: _____

2: The Member

Name: _____

Address:_____ State: _____Postcode: _____

Phone: (Work): _____ Mobile: _____

Email Address:_____

Occupation: _____

Date of Birth: ____ / ____ / ____ Sex: ☐ Male ☐ Female

Licence Number: _____

To be completed by rider

I hereby authorise any hospital, physician or other person who has attended to me, or any employer, to furnish QBE Insurance (Australia) Limited, or its representatives, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorization 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 fraudulent statements or conceal, or suppress, or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sickness shall be forfeited.

Signature		***Date***	

3: Details of the Member's Injury

What is the nature of **Your** injury? _____

What body part/s has been injured? _____

Is it a recurrence of a previous injury? ☐ Y ☐ N

How did it happen? _____

_____

_____

Where were **You** when it happened? _____

_____

_____

3: Details of the Member's Injury (continued)

Type of location: ☐ Velodrome ☐ Training - Road ☐ Event Course - Road ☐ Other

If 'Other' please describe: _____

When did the injury occur? ____ / ____ / ____ Time: _____

What were **You** doing? ☐ Racing ☐ Warm up ☐ Training ☐ Other sport

If 'Other' please describe: _____

What was the event? ☐ Competition ☐ Regular Sanctioned training ☐ Training camp ☐ Other

If 'Other' please describe: _____

4: Details of the Member's treatment

Name and address of each hospital **You** attended: _____

_____

Date of: Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____

Name, address and phone numbers of all attending doctors: _____

_____

_____

_____

Name, address and phone number of **Your** usual doctor _____

_____

_____ State: _____Postcode: _____

5: Details of the Member's previous Disabilities, injuries or claims

Were **You** suffering any previous medical condition? ☐ Y ☐ N

If 'Yes', give details of the condition: _____

_____

_____

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? ☐ Y ☐ N

If 'Yes', what was the date of injury ____ / ____ / ____

Who was the insurer? _____

How much were **You** paid? _____

What was the injury? _____

Name and address of the doctor: _____

_____ State: _____Postcode: _____

6: Details of the Member's insurance

Are **You** a member of a health fund? ☐ Y ☐ N

If 'Yes', what type of membership do **You** have? ☐ Hospital cover only ☐ Ancillary cover only ☐ Hospital plus ancillary benefits

Name of health fund: _____

Membership number: _____

Any other details regarding private health cover: _____

_____

Do **You** have any other insurance to cover this disability or Injury? ☐ Y ☐ N

If 'Yes', please show name and address of insurer _____

_____ State: _____Postcode: _____

7: Illegal Substances and intoxicating liquor

Were **You** under the influence of any Illegal Substances or intoxicating liquor when the disability or injury took place

☐ Y ☐ N

If 'Yes", please give details: _____

_____

Have **You** taken any performance enhancing drugs? ☐ Y ☐ N

8: The Member's declaration

By signing this claim form I declare that:

1. All the information that I have given in this form is correct
2. I authorise any doctor, hospital or other person who has treated me to provide OAMPS Insurance Brokers Ltd. or its representative with any medical records for any illness or injury I have suffered.
3. I authorise my employer to provide OAMPS Insurance Brokers Ltd. or its representative with details of my salary and working hours.
4. I agree that a photocopy of this authorisation will be accepted as valid.
5. I agree to allow the insurer to ask or tell other insurers or insurance reference bureaux about this or any other claim I have made.

Must be completed by the injured **Member**

Signature: _____ Date: ____ / ____ / ____

9: The Member's employment details (Must be completed by pay clerk/paymaster)

Employer's name: _____

Employer's address: _____

_____ State: _____ Postcode: _____

Phone number: _____

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury. *(Excluding bonuses, commissions, overtime or any other allowances)* $_____

Date **You** expect **Your** employee to resume work ____ / ____ / ____

Date **You** expect **Your** employee to resume normal duties (fully fit) ____ / ____ / ____

What is **Your** employee's gross annual salary? $ _____

What date did he or she commence employment? ____ / ____ / ____

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury
(net of business expenses, but before income tax and personal deductions e.g. Tax Return)

What is the name of **Your** pay clerk? _____

What is **Your** pay clerk's phone number? _____

Signature of pay clerk / paymaster: _____ Date: ____ / ____ / ____

10: Club Veteran Cycling Council declaration

Must be completed by the Club Secretary or Treasurer

I _____ *Secretary or Treasurer*

of _____ *Name of club and association*

Confirm that _____ *Member's name*

Sustained the injuries resulting in this claim on:

_____ *Date* at _____ *Time*

While training or racing for _____ *Team*

During the _____ AVCC *Sanctioned Event*

or while taking part in _____ *Activity*

at _____ *Place of activity*

The first consultation with a doctor for this injury was on:

_____ *Date*

at _____ *Address of doctor*

Signature: _____ Date: ____ / ____ / ____

Club mailing address: _____

_____ State: _____ Postcode: _____

11: State Veteran Cycling Council declaration

Must be completed by the State Secretary or Treasurer

I _____ *Secretary or Treasurer*

of _____ *Name of State and association*

Confirm that _____ *Member's name*

Sustained the injuries resulting in this claim on:

_____*Date* at _____ *Time*

While participating in the advised activity described in part 10.

Signature: _____Date: ____ / ____ / ____

Club mailing address: _____

_____ State: _____Postcode: _____

State Association/OAMPS Office Use Only

Player Registration Number: _____

Signed: _____

Position: _____

State Association Stamp Where Applicable: _____

Injury data collection

OAMPS Insurance Brokers Ltd is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. OAMPS Insurance Brokers Ltd, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was **Your** role at the time of Your injury?
☐ Participant ☐ Coach ☐ Umpire/Referee ☐ Other Official
☐ Voluntary Worker ☐ Spectator ☐ Other

If 'Other' please provide details: _____

How far into the activity were **You** at the time of the injury?
(Note: Your answer relates to the time into the activity, rather than the period/stage of the game))
☐ Warm up ☐ During Race
☐ Training ☐ Cool Down

On what surface were **You** participating?
☐ Grass ☐ Synthetic Surface ☐ Wooden Floor
☐ Gravel ☐ Concrete/Bitumen ☐ Other

If 'Other' please provide details: _____

What was the condition of the surface?
☐ Normal ☐ Hard ☐ Wet ☐ Muddy ☐ Other

If 'Other' please provide details: _____

What were the weather conditions as the time of injury?
☐ Fine ☐ Light Rain ☐ Heavy Rain ☐ Other

If 'Other' please provide details: _____

What were the temperature conditions at the time of injury?
☐ Very Hot ☐ Hot ☐ Hot & Humid ☐ Mild
☐ Cold ☐ Very Cold ☐ Windy ☐ Other

If Windy please provide details of conditions – knots, direction etc _____

If 'Other' please provide details: _____

How was the onset of injury?
☐ Sudden ☐ Gradual ☐ Started With Pre-Existing Injury

If a collision injury, what did **You** collide with?
☐ Ground ☐ Equipment ☐ other rider ☐ Other Structure

If 'Other' please provide details: _____

Was protective equipment, including Australian Standard Approved Helmet, tape or support being worn on the injury site?

☐ Yes ☐ No

If yes, please provide details:

☐ Taping ☐ Protective Equipment ☐ Other Support

If 'Protective equipment', please provide details:

If 'Other support', please provide details:

How did the injury severity affect Your Participation?

☐ Unable to Continue ☐ Continued to participate After Treatment
☐ Continued to participate Without Treatment

What was the immediate treatment? (more than one box may be ticked)

☐ Rest ☐ Ice ☐ Compression ☐ Elevation
☐ Stretching ☐ Mobilisation ☐ Taping ☐ Bandaging
☐ Sling ☐ Splint ☐ Other ☐ Unknown

If 'Other' please provide details:

Was a first aid officer present at the event?

☐ Yes ☐ No ☐ Unknown

If Your injury required referral, to whom were **You** referred?

☐ Hospital ☐ Doctor ☐ Physiotherapist ☐ Dentist ☐ Other

If 'Other' please provide details:

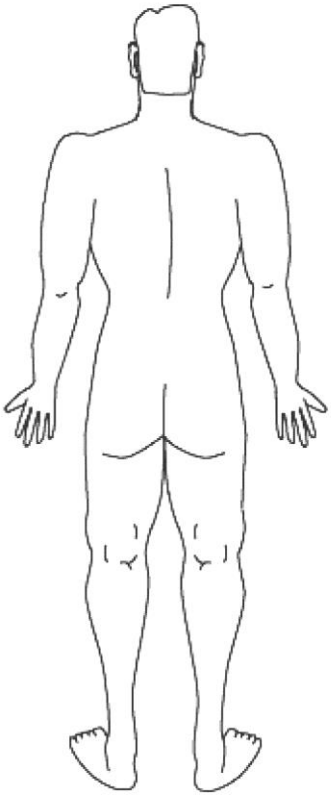
If immediate off site treatment was necessary, what mode of transport was used?

☐ Ambulance ☐ Private Vehicle ☐ Event Medical Services ☐ Other

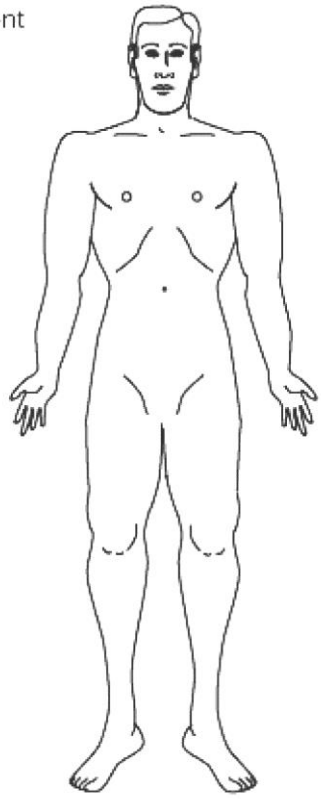
If 'Other' please provide details:

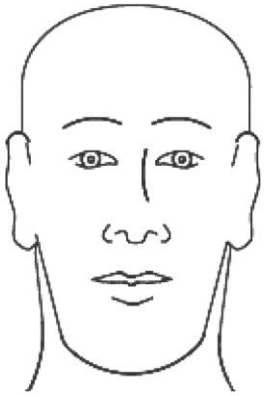
Please indicate the site of your injury on the appropriate diagram below:

Back



Front





Head

Medical statement

This form must be completed by the registered medical doctor treating the injury

The AVCC Association and Club

Association name: _____

Club name: _____

Type of sport: _____

The Member

Name: _____

Address: _____ State: _____ Postcode: _____

Date of Birth: ____ / ____ / ____ Sex: ☐ Male ☐ Female

The injury

Complete Diagnosis _____

_____

_____

_____

History

When did the present disability or injury occur? ____ / ____ / ____

Date the player ceased work: ____ / ____ / ____

Is there a history of the same or similar condition? _____

Is this a recurrence? ☐ Y ☐ N

Present condition

Subjective symptoms: _____

_____

Objective finding *(give reports of any x-rays, ECGs or other tests)* _____

_____

_____

_____

Is the player ☐ Walking ☐ Bed confined ☐ House confined ☐ Hospital confined

Date of admission: ____ / ____ / ____

Treatment of present condition

Date of first consultation: ____ / ____ / ____

Date of latest consultation: ____ / ____ / ____

Frequency of consultations: _____

Date of last hospitalisation: ____ / ____ / ____

Name of hospital:_____

Nature of surgical procedure: _____

_____ _ ☐ Contemplated ☐ Performed

Progress

If performed: ____ / ____ / ____

Has condition improved? ☐ Y ☐ N

If 'No', please explain:

Degree of disability

Has the patient been able to do any work?

If 'No', from what date Regular work: ____ / ____ / ____ Light duties: ____ / ____ / ____

When will the patient be able to resume for Regular work: ____ / ____ / ____ Light duties: ____ / ____ / ____

Other treatment

If the patient was seen in consultation. ____ / ____ / ____

by another doctor, please give the date,
name and address of that doctor

_____

_____ State: _____Postcode: _____

If the patient is no longer under your care, what date were your services terminated? ____ / ____ / ____

Other conditions

Describe any other disease or infirmity affecting the patient's present condition: _____

_____

_____

_____

Please complete the appropriate section if the disability or injury is due to:

Cardiac-circulatory

Blood pressure: _____

Circulatory disorder – please describe: _____

_____

_____

Visual

Is the patient totally or industrially blind? ☐ Y ☐ N

If 'No', what was the vision at
last observation: With glasses: ☐ Distant ☐ Near Date: ____ / ____ / ____

Without glasses: ☐ Distant ☐ Near Date: ____ / ____ / ____

What is the extent of any gross visual field defect?_____

Could vision be improved by treatment, surgery or lenses? ☐ Y ☐ N

What are the rehabilitation prospects? _____

_____

_____

Orthopedic

Please report findings of specialist if referred? _____

_____

_____

Neurological

Please report findings of specialist if referred? _____

_____

_____

Prognosis

_____

_____

Remarks

_____

_____

Signature: _____ Date: ____ / ____ / ____

Degree: _____

Name of Doctor
*(please print):*_____

Address:_____

_____

_____Postcode: _____

Please apply doctors name stamp below

Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

Loss of income claim (if eligible)

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete**
2. **Please forward your completed Sports Injury Claim Form to your Club Secretary who will on forward to the State Secretary for completion of declaration. It would be appreciated if the State Secretary could forward the claim form to OAMPS within 30 days of injury.**
3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for OAMPS Insurance Brokers Ltd. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer your complaint to the Insurance Broking Division of the Financial Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the OAMPS web site at **www.oamps.com.au** or telephone 1800 240 432.

Claims Handling

Claims are processed at OAMPS Brisbane office State Secretary's, please forward the completed claim form to:

Brisbane

Level 2, 601 Coronation Drive Toowong Qld 4066
T: 07 3367 5000
F: 07 3367 5100
brisbane@oamps.com.au