



BASKETBALL AUSTRALIA PERSONAL INJURY CLAIM FORM

IMPORTANT INFORMATION: PLEASE READ CAREFULLY

Dear Basketball Australia member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.
2. Please ensure that you fully complete Section A and sign and date the Declaration.
3. Please ensure that a Club Official completes and signs the Club Declaration in Section B.
4. For claims involving Loss of Income:-
 - a) you must arrange for your employer/salary officer to complete Section C. If self employed, you must have your accountant complete these details;
 - 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.)
5. For claims involving medical expenses:-

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).
6. Please attach all 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.

Please note:

No cover is provided for Surgeons, Anaesthetists, 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.

7. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to Basketball Victoria or Basketball Victoria Country Council who will sign the State Body Declaration in Section B.

Basketball Victoria
Box 3
Melbourne Sports & Aquatic Centre
Aughtie Drive
ALBERT PARK VIC 3206

Basketball Victoria Country Council
PO Box 463
BENDIGO VIC 3552

8. Basketball Victoria or Basketball Victoria Country Council will then forward your completed claim form and relating documentation directly to the insurer on your behalf:-

American International Group
GPO Box 4363
MELBOURNE VIC 3001

American International Group will confirm receipt of your claim form within 5 working days. They will advise you of your claim number and where to send any ongoing medical receipts and other relating documentation. Your reimbursement cheque will be sent to you directly by American International Group.

9. If you have any further queries relating to your claim, Benefits, Excesses or Special Conditions/Exclusions, please do not hesitate to contact the Horsell International Sports Team on:-

Phone: (02) 9247 1700
Fax: (02) 9247 1733
Email: sports@horsell.com
Website: www.horsell.com



SECTION B. TO BE COMPLETED BY THE CLUB (NOT TO BE COMPLETED BY THE PLAYER)

CLUB DECLARATION (please advise the claimant of the Policy coverage as per your Schedule of insurance).

I, of
 (Official) (Name of Club)

Hereby Certify that sustained the injuries resulting in this claim on / /
 (Name of Player) (date)

At am/pm whilst playing/training for
 against Place of Game

Signed: Dated: / /
 (club official)

TO BE COMPLETED BY THE STATE BODY (I.E. BASKETBALL VICTORIA OR BASKETBALL VICTORIA COUNTRY COUNCIL)

STATE BODY DECLARATION (please advise the claimant of the Policy coverage as per your Schedule of insurance).

I, of
 (State Body Official) (State)

Hereby Certify that is a registered member of Basketball Victoria and I
 (Name of Player)

hereby sign this form in acknowledgement of the claim being made.

Signed: Dated: / /
 (State Body Official)

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 / /		
EMPLOYEE WEEKLY SALARY AS AT DATE OF INJURY NET \$..... GROSS \$..... (If Self employed, provide average weekly salary based on 12 month period directly prior to injury)		DATE COMMENCED EMPLOYMENT WITH COMPANY / /		
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.				



SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

Surname:

Given Names:

Injury Date:

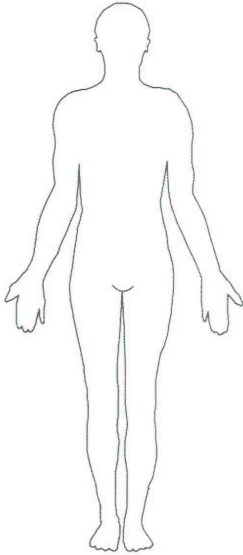
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

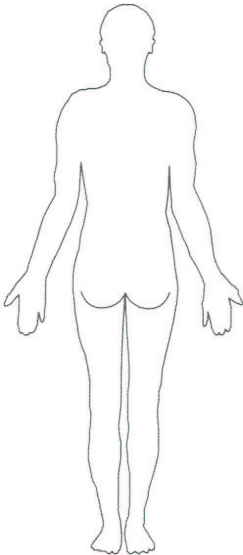
THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO HORSELL INTERNATIONAL OR AMERICAN INTERNATIONAL GROUP

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.....

(Continued: See Over)

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:/...../.....



BASKETBALL VICTORIA

SPORTS INJURY & PERSONAL ACCIDENT INSURANCE

FOR PERIOD 1 APRIL 2006 TO 1 APRIL 2007



WHO IS COVERED?

All registered & trialling members, coaches, assistant coaches, voluntary workers, officials, employees, members of the board of management, administrators, directors and executives.

WHEN ARE YOU COVERED?



Cover applies:

- a) Engaging/Playing in official club matches including club, championship or representative matches.
- b) Organised training or practice sessions for activities as described in (a) above.
- c) Travelling directly between matches/activities in (a) or (b) above, and your residence or place of employment or the premises of Basketball Australia or its affiliated Associations, Leagues or Clubs.
- d) Staying away from your home district during a tour for the purpose of participating in representative matches/activities.
- e) Engaging in administrative or organised social activities of Basketball Australia or its affiliated Associations, Leagues or Clubs.

NOTE: Some fundraising and extreme training techniques may not be covered by the definition of "Activities Covered" in this policy. Please refer to Horsell International for confirmation that the activity is covered.

WHAT COVER APPLIES?

The benefits are summarised below.

MEDICAL EXPENSES

Pays 75% of any Non-Medicare medical expenses up to a maximum of \$1,000 any one injury. Claimable expenses include physiotherapy, private hospital, ambulance, dental etc, net of any Recoveries from private health insurance.

An excess of \$50 applies to each injury. Nil excess applies for claimants who are privately insured.

NOTE: The gap between a doctor's account and the Medicare rebate is not covered. This also applies to Surgeons, anaesthetists and x-rays. Non Medicare Medical costs are only reimbursed by this policy if incurred 52 weeks from the date of the injury.

LOSS OF INCOME

Cover for 80% of your net weekly income or up to a maximum of \$200 per week, whichever is the lesser.

Benefit Period: 52 weeks
Excess: 7 days

DEATH & PERMANENT DISABILITY

A lump sum benefit is payable in the event of a death or a Permanent Disability. The scale of benefits is defined in the policy.

The maximum benefit is \$100,000

(Other than anyone under 18 years \$20,000 maximum)

STUDENT ASSISTANCE BENEFIT

Pays 80% up to \$200 per week for 52 weeks for any one claim of the actual cost of home tutorial by a qualified tutor which has been certified as necessary for the duration of total disablement by a registered and legally qualified medical practitioner up to the policy limits

Excess: 7 days

HOUSEHOLD HELP ALLOWANCE

Pays non-wage earners up to 80% of costs or a maximum of \$200 per week for 52 weeks for any one claim being for reimbursement of actual costs of domestic help certified as necessary for the duration of total disablement by a registered and legally qualified medical practitioner up to the policy limits.

Excess: 7 days

FUNERAL EXPENSES

Pays 100% of the actual costs of funeral expenses of an insured person up to a maximum of \$5,000.

PARENTS INCONVENIENCE ALLOWANCE

Pays 80% of parent's actual costs to a maximum of \$200 per week to a maximum of \$2,000 in total any one claim for 52 weeks whilst their child is hospitalised to off set costs incurred for baby sitting, taxi fares etc.

HOW DO I MAKE A CLAIM?

1. Obtain claim forms from your Club or Association or from Horsell International – www.horsell.com
2. Have the claim form fully completed as per instructions provided on the claim form.
3. Should you have any questions on how to make a claim, please contact the insurance brokers managing this program:

Horsell International Pty Limited - Level 12, 189 Kent Street, Sydney NSW 2000

Ph: (02) 9247 1700 or Outside Sydney Metro Area 1300 722 990

This insurance is underwritten by American Home Assurance Company (AIG)

IMPORTANT NOTES

1. This information is only a summary of the cover provided. The policy with full conditions is held by Basketball Australia
2. Retail Client Documents – Financial Services Guide, Statement of Advice and Insurers Product Disclosure Statement are available from Horsell International or via www.horsell.com
3. If you would like to increase any of the above benefits, please contact Horsell International.



RISK MANAGEMENT INFORMATION

The following information is required for basketball injury research to assist with risk management, answering these questions will not affect your claim.

1. NAME:
2. DATE OF INJURY?/...../.....
3. INJURY SITE (e.g. ankle, knee, etc.)?
4. INJURY NATURE (e.g. sprain, break, ligament tear, etc.)?
5. a) ASSOCIATION NAME?
b) GRADE?
c) PLAYING POSITION AT TIME OF INJURY?
d) WHERE DID YOUR INJURY OCCUR? <input type="checkbox"/> INDOOR <input type="checkbox"/> OUTDOOR
e) SURFACE AT POINT OF INJURY? <input type="checkbox"/> TIMBER <input type="checkbox"/> SYNTHETIC <input type="checkbox"/> CONCRETE/BITUMEN <input type="checkbox"/> OTHER.....
f) WEATHER CONDITIONS? <input type="checkbox"/> FINE <input type="checkbox"/> RAIN <input type="checkbox"/> OTHER.....
g) SURFACE CONDITIONS? <input type="checkbox"/> WET <input type="checkbox"/> DRY <input type="checkbox"/> INDOOR <input type="checkbox"/> OTHER.....
h) INJURY CIRCUMSTANCES? <input type="checkbox"/> OFFICIALLY ORGANISED COMPETITION <input type="checkbox"/> SOCIAL/PRIVATE COMPETITION
<input type="checkbox"/> OFFICIALLY ORGANISED PRACTICE <input type="checkbox"/> SOCIAL/PRIVATE PRACTICE
<input type="checkbox"/> TRAVELLING <input type="checkbox"/> OTHER.....