Sports Underwriting Australia
Sports Injury Claim Form

Sports Underwriting Australia Claims Department

E: austclaims@aig.com
Ph: 1800 812 363
Post: AIG Australia, GPO Box 4363, Melbourne, Vic, 3001

IMPORTANT NOTICES

Your Duty of Disclosure

This Policy is subject to the Insurance Contracts Act 1984 (Act). Under that Act you have a Duty of Disclosure.

Before you take out insurance with us, you have a duty to tell us of everything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms. If you are not sure whether something is relevant you should inform us anyway.

Dispute Resolution Process

If you are not satisfied with our service please tell us so we can help. We will address complaints in accordance with AIG Australia Limited's Complaints Handling Process and the Insurance Council of Australia's Code of Practice. If you have a complaint:

Step 1: Contact us

You can contact us by:

Postal Address: PO Box 288, Kew East Victoria. Australia 3102
Tel: +61 3 8862 2600
Email: info@sportsunderwriting.com.au

If we require additional information we will contact you to discuss. If your complaint is not immediately resolved we will respond within 15 business days of receipt of your complaint or agree on a reasonable alternative timetable with you.

Step 2; AIG Complaints Process

If this does not resolve the matter or you are not satisfied with the way a complaint has been dealt with, you can register a complaint with us by telephoning us on 1800 339 669, lodging your complaint on our website, or by writing to:

The Compliance Manager
AIG Australia Limited
Level 12, 717 Bourke Street
Docklands VIC 3008

As soon as we receive your complaint we will take all possible steps to resolve it. You will receive a written response to your complaint within 15 working days, unless we agree a longer timeframe with you.

What should you do if you are not happy with our response to your complaint?

If you are not satisfied with our response to your complaint, you may wish to have the matter reviewed by our Internal Dispute Resolution Committee ("Committee"). The Committee is comprised of Senior Management of the company who have the experience and authority to decide on matters brought to the Committee.

If you wish to have your complaint reviewed by this Committee please telephone or write to the person who has signed the response letter to your complaint and provide them with detailed reasons for requesting the review. This information will greatly assist the Committee in reviewing your claim or enquiry. Your complaint will then be treated as a dispute. You may also make a request for a review by the Committee by contacting:

The Chairperson IDRC
AIG Australia Limited
Level 12, 717 Bourke Street
Docklands VIC 3008

A written response setting out the final decision of the Committee and the reasons for this decision will be provided to you within 15 working days of the date you advise us you wish to take your complaint to IDRC.

If we are unable to provide a written response setting out the final decision we will keep you informed of progress at least every 10 days.

If you are not satisfied with the finding of the Committee, or if we have been unable to resolve your complaint within 45 calendar days, you may be able to take your matter to an independent dispute resolution body, the Financial Ombudsman Service ("FOS"). This external dispute resolution body can make decisions with which AIG are obliged to comply. Contact details are:

Financial Ombudsman Service Australia (FOS)
if lodged before 1 November 2018:
Online: www.fos.org.au
Email: info@fos.org.au
Phone: 1800 367 287 (free call)
Mail: Financial Ombudsman Service Australia, GPO Box 3, Melbourne VIC 3001

or

Australian Financial Complaints Authority(AFCA)
if lodged on or after 1 November 2018:
Online: www.afca.org.au
Email: info@afca.org.au
Phone: 1800 931 678 (free call)
Mail: Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001

FOS and AFCA provide fair and independent financial services complaint resolution that is free to consumers. Time limits may apply to complain to FOS or AFCA and so you should act promptly or otherwise consult the FOS and AFCA websites to find out if or when the time limit relevant to your circumstances expires.

If the matter does not fall within the jurisdiction of FOS or AFCA, you are not precluded from exercising any legal rights you may have or from accessing any other external dispute resolution options that may be available to you.

Privacy Statements

Sports Underwriting Privacy Notice

In this Privacy section "we", "us" or "our" means Sports Underwriting Australia, unless specified otherwise.

We are committed to the safe and careful use of your personal information in the manner required by the Privacy Act 1988 (Cth) and the Australian Privacy Principles.

We collect your personal information in order to assess your application for insurance and, if your application is accepted, to administer and manage your Policy and respond to any claim that You make. To do this, your personal information may need to be disclosed to reinsurers and service providers and related entities who carry out activities on our behalf, such as assessors and facilitators, some of whom may be located in overseas countries. Our contractual arrangements generally include an obligation for these reinsurers, service providers and related entities to comply with Australian privacy laws.

By providing us with your personal information, you consent to the disclosure of your personal information to reinsurers, service providers and related entities in overseas countries to enable us to assess your application, to administer and manage your Policy and to respond to any claim that you make. If you consent to the disclosure of your personal information to overseas recipients, and the overseas recipient handles your personal information in a way other than in accordance with the Australian privacy laws, we may not be responsible for the handling of your personal information by the overseas recipient.

If you choose not to provide your personal information and/or choose not to consent and / or withdraw your consent to the disclosure of your personal information at any stage, we may not be able to assess your application or administer and manage your insurance policy and respond to any claim that you make.

Our Privacy policies contain information on how you may access personal information that each of us hold, or seek correction of Your personal information and information on how to make a complaint about the handling of your personal information and how complaints are handled. If you require more information, you can access the SUA Privacy Policy and Privacy Statement at www.sportsunderwriting.com.au/documents.html.

AIG Australia ("AIG") Privacy notice

AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including data analytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Failure to disclose information required may result in AIG not being able to administer or declining the claim.

AIG may disclose your information to:

- your or our agents, AIG related entities, reinsurers, contractors or third party providers providing services related to the administration of the claim;
- assessors, third party administrators, emergency providers, retailers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim;
- entities to which AIG is related and third party providers for data analytics functions; and
- government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

Some of these entities may be located overseas, including in United States of America, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which you have a claim and such other countries as may be notified in our Privacy Policy from time to time.

Our Privacy Policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicable privacy principles and how AIG will deal with such a complaint.

Taxation Information

The amount of cover available under this Policy excludes Goods and Services Tax (GST).

If you are not registered for GST, in the event of a claim we will reimburse you the GST component in addition to the amount that we pay.

The amount that we are liable to pay under this Policy will be reduced by the amount of any input tax credit that you are or may be entitled to claim for the supply of goods or services covered by that payment.

If you are entitled to an input tax credit for the Premium you must inform us of the extent of that entitlement at or before the time you make a claim under this Policy. We will not indemnify you for any GST liability, fines or penalties that arise from or are attributable to your failure to notify us of your entitlement (or correct entitlement) to an input tax credit on the Premium.

If you are liable to pay an Excess under this Policy, the amount payable will be calculated after deduction of any input tax credit that you are or may be entitled to claim on payment of the Excess.

If you are unsure about the taxation implications of this Policy, you should seek advice from your accountant or tax professional.

Members Name:									
Address:							Post Code:		
Telephone:	Home -		Work -		Mobile -				
Email:									
Date of Birth:		Height:		Weight:		Sex:	☐M / F☐		
Normal occupation prior to disablement:									
Name of Club, Grade & Team:			Membership Number:			Period/Expiry of Membership			

DETAILS OF INJURY:

A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).

Type of Injury:		Please describe how the injury occurred	
Address where you were injured:			

Date of Injury:		Time:		Training:	Yes ☐	No ☐	Playing:	Yes ☐	No ☐

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition (s):		Date:		Treated By:	

Advise when you did (or expect to):

Cease work/normal activities _____
Cease training _____
Cease participating _____
Resume work/normal activities _____
Resume training _____
Resume participating _____

To be completed by the Club Official / Secretary / Treasurer.

Please ensure that all questions have been fully answered.

Name of Member				was injured as stated.	
Type of Member					
Name of Club					
Official Name		Official Position		Telephone	
Address of Club / Association				Post Code	

I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.

Signature		Date		Witness		Date	

Details of Non Medicare expenses claimed.

NB: It should be noted that the policy does not provide cover any services that are subject to a Medicare Rebate as the Health Insurance Act (1984) does not permit us to contribute to any charges covered by Medicare, including the Medicare Gap. This includes surgery costs, surgeon's fees, anaesthetist's fees, doctor's fees, x-rays and ultrasounds.

Are you a member of a private health fund? Yes ☐ No ☐

If yes, which one?

Hospital Cover Yes ☐ No ☐ Extras covering dental, physio, etc. Yes ☐ No ☐

Ambulance Cover Yes ☐ No ☐

Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)					
b)					
c)					
d)					

When did you first consult a physician for this condition?	
When did you become totally disabled (unable to work)?	
When were you able to again perform part of your occupational duties?	
If still totally disabled, when do you expect your disability to terminate?	
When will you resume playing?	

Hospital	Addresses	From	To

a. Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

b. Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)

Name	Address	Telephone

LOSS OF INCOME

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

	(please tick the box) Yes	No
1. Can compensation be claimed under worker's compensation or any other insurance or any other insurance including Loss of Income?	☐	☐
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?	☐	☐
3. Have you engaged in any other income earning employment since you have been injured?	☐	☐

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER/SALARY OFFICER. IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer:	State Postcode
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. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

☐ Self Employed ☐ Full Time ☐ Part Time ☐ Casual

During the period of incapacity the employee has received

$	Normal Pay	From	……/……/……	to	……/……/……
$	Sick Pay	From	……/……/……	to	……/……/……
$	Workers' Compensation	From	……/……/……	to	……/……/……
$	Other (please specify)	From	……/……/……	to	……/……/……

Has the employee returned to work? ☐ Yes ☐ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ☐ Yes ☐ No

A. IF EMPLOYED

Salary officers name:	Phone Number: ( )
Salary officers signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountants Company Stamp:	Date: / /

Are you claiming or entitled to claim any other form of benefit (eg. Work Cover, Superannuation Injury Cover, etc.)? If so, please provide details.

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Declaration

I declare that, to the best of my knowledge and belief, the information in this form is true and correct and I understand the claim may be refused or reduced if information is withheld.

I understand that I may have to provide relevant documentation to enable complete consideration of my claim.

I consent to AIG and Sports Underwriting Australia collecting, using and disclosing personal information as set out in the privacy notices found in this form. If I have provided or will provide information to AIG or Sports Underwriting Australia about any other individuals, I confirm that I am authorised to disclose his or her personal information to AIG or Sports Underwriting Australia and also to give this consent on both my and their behalf.

I consent to the disclosure of sensitive information to third parties in order to process my claim. I consent to the disclosure of any personal information (including sensitive information) overseas where it is reasonably necessary for the processing of my insurance claim. I understand that if this consent is not given AIG and Sports Underwriting will not be able to process this insurance claim.

Signature of insured or person with authority to sign for and on behalf of a company or partnership.

Signature:_____

Date:_____/____/_____

Please indicate the number of additional pages attached to this claim form:

METHOD OF PAYMENT
Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account
Please indicate your preferred method of payment (please tick) ☐ Cheque ☐ EFT
If you would like your payment made by EFT, please complete the details below.
NAME OF CLAIMANT
Title: ☐ Mr ☐ Mrs ☐ Miss
Name:
BANK ACCOUNT DETAILS
BSB number (all 6 digits are required here) ☐☐☐☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐
Nominated account name:
Bank, Credit Union, Building Society name:
Branch:

Attending Physicians Statement

To be completed by a registered medical practitioner

(The insured is responsible for completion of this form without expense to the company)

Patients Name		Address		Sex	M/F ☐ ☐
What is disabling patient? (Please give a complete diagnosis of this condition)					

HISTORY:

1. When did patient first receive medical treatment?			
2. Was there a previous history of this or a similar condition?	Yes ☐	No ☐	
If yes, please state condition and advise when previous treatment given.			
3. a) How long have you known the patient?			
b) Are you the regular general practitioner? If no please advise who is?	Yes ☐	No ☐	

IF INJURY:

1. When did patient suffer the injury?	
2. What were the circumstances surrounding the injury?	

IF DISABILITY:

1. Patients occupation?			
2. When was patient obliged to cease work?			
3. If patient still disabled, when will the patient be able to commence any type of employment?			
a) some duties		b) full duties	
4. If patient has recovered, when was patient able to resume.			
a) some duties		b) full duties	

TREATMENT OF PRESENT CONDITION

1. When were you consulted?			
a) initially?		b) most recently?	
2. How often has patient consulted you?			
3. Was patient confined to hospital?	Yes ☐	No ☐	
If yes please advise Hospital Name			
Address			
Period of confinement	From	To	
4. Was confinement in a convalescent home necessary after hospitalisation?	Yes ☐	No ☐	
If yes please give details.			
5. What are the current subjective symptoms.			
6. Please give results of any objective finding.			
a) X-rays			
b) Other test - Please advise test done and findings			
7. What surgical procedures have been performed?			
8. What surgical procedures have been contemplated?			
9. What other treatment has the patient undergone?			
10. What other treatment is required?			
Are there any underlying conditions affecting recovery from the current condition?	Yes ☐	No ☐	
If yes please advise nature of underlying conditions and how they affect disability and recovery.			
Has patient any other physical or mental impairment?	Yes ☐	No ☐	
If yes, please describe.			
Please advise names and addresses of other treating physicians.			

Name	Address	Telephone

Has the patient finished all treatment, if yes what date?		If no, what is your estimated treatment time frame	
What is your current prognosis?			
Are there any further remarks which may assist in assessing this condition?			
Is there any permanent disability present?	Yes ☐	No ☐	
If yes, please explain giving estimated percentage of loss of function.			

Name (please print name):	Address:	Telephone:
Position:		
Signature:	Degree:	Date: