Karting Australia

Sports Injury Rehabilitation Claim Form

Gallagher

KARTING AUSTRALIA

Injured

Injured *(please tick)*:

☐ Driver ☐ Crew Member ☐ Pit / Service Crew ☐ Official ☐ Volunteer

Club:

Name:

Address:

City:

State: Postcode:

Phone:

Date of Birth: / /

Sex

☐ Male ☐ Female

Email:

Event

Track Name:

Track City:

Event Name:

Event Type:

Vehicle Type:

Vehicle Number:

Details of disability or Injury

Date of injury:

Injured body part:

Injury type *(Sprain, fracture, concussion etc.)*:

Time

☐ Morning ☐ Afternoon ☐ Evening ☐ Lights

Disposition

☐ On-Site Care Only ☐ Ambulance to Hospital ☐ Fatality ☐ Refused Treatment

Occasion

☐ Morning ☐ Pre-race Preparation ☐ Qualifiying Run / Trials ☐ During Race ☐ During Race / Yellow Flag
☐ Between Races ☐ Non-Race Business

Location

☐ Garage Area ☐ Pits (Entrance / Exit) ☐ Starting / Staging Area ☐ Turn #
☐ Straightway ☐ Grandstand ☐ Other

If 'Other' please provide details:

Activity

☐ Racing ☐ To / From Pits ☐ Vehicle Maintenance Report

☐ Loading / Unloading ☐ Other

If 'Other' please provide details:

Situation

☐ Hit by Racer ☐ Hit Racer ☐ Hit Fence / Wall

☐ Hit by debris (log/rock, vehicle part) ☐ Fell (slip, trip, pushed) ☐ Other

If 'Other' please provide details:

Special Circumstances

☐ Lost Wheel ☐ Left ☐ Right ☐ Front ☐ Rear

☐ Stuck Throttle ☐ Wet Track ☐ Other

Estimated Absence from Racing

☐ Less than 1 week ☐ 1-3 weeks ☐ More than 3 weeks ☐ Not Applicable

Describe how the accident happened:

Person who can attest to injury:

Print Name:

Phone:

Was there anyone else injured?

Treatment

Was hospital treatment required?

☐ Yes ☐ No

If 'No' did you visit your GP? If 'Yes' GP details:

Name of Doctor:

Address:

Hospitals - if you were admitted to hospital, or treated as an out-patient, please give details:

	Name	Address	From	To
Inpatient				
Outpatient				

Give details of all attending physicians:

Name	Address	Telephone number

When did you stop work: / / *(date)* AM/PM *(time)*

When did you first obtain treatment from a doctor: / / *(date)* AM/PM *(time)*

Name of Doctor:

Address:

Is this Doctor still treating you for the injury?

☐ Yes ☐ No

Is this your regular doctor?

☐ Yes ☐ No

If 'No' give details:

Regular Doctors Name:

Address:

State: Postcode:

Is there any injury (past or present) affecting your current disability?

☐ Yes ☐ No

If 'Yes' give details:

Are you now:

☐ Recovered When did you return to work? / /

☐ Partially Disabled When did you return to work? / /

☐ Totally Disabled When do you expect to return to work? / /

Have you made, or will you make a claim for benefits under any Workers Compensation Act or Ordinance because of the injury?

☐ Yes ☐ No

If 'Yes' please give details:

	Name	Address
Employer		
Workers Compensation Insurer		

Are you entitled to claim benefits from any Health Fund, Friendly Society?

☐ Yes ☐ No

Name of Fund:

Address:

If so what benefits will you be claiming:

Have you or will you make a claim for benefits under a Road Traffic Policy (CTP)

☐ Yes ☐ No

Name of Insurer:

Addresss:

Do you have any other insurance to cover this disability or Injury?

☐ Yes ☐ No

If 'Yes' give details:

Name of Insurer:

Address:

State: Postcode:

Your employment details

If employed as wage earner

Must be completed by pay clerk/paymaster

Employer's name:

Employer's address:

State: Postcode:

Phone number:

Email:

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? / /

What is the name of Your pay clerk?

What is Your pay clerk's phone number?

What is Your pay clerk's email address?

Signature of pay clerk / paymaster: Date: / /

If self employed

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)

Who is your accountant?

Accountant's Name:

Accountant's Address:

State: Postcode:

Phone number:

Disclosure Statement and Privacy Consent

Gallagher and the underwriter as specified on the policy schedule is committed to protecting the privacy of the personal information you provide to us.

We will use the personal information requested on this form to enable us to consider your claim. We may also need to collect additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if your claim is investigated by us.

If you do not provide us with this information, we may not be able to process your claim. We may disclose your personal information we collect on this form and any other additional information we collect in relation to this claim:

- to our relevant staff and contractors involved in delivering our services;
- if a broker collects the claim form from you, to that broker (this is applicable to the claim from only);
- to your employer;
- to your sports association to confirm your eligibility to claim under a policy arranged by it;
- to the insurer and the underwriter as specified on the policy schedule;
- to reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- to facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- to consultant doctors and physicians (in connection with the handling of your claim);
- to claims investigators and surveillance officers (in circumstances where the claim is investigated by us);
- if required to do so by a law enforcement body or by law; and

You may request access to your personal information we hold about you and where necessary, correct any errors in this information (some restrictions and costs may apply).

By completing and returning this form and agreeing to us collecting additional information from the parties specified above in connection with your claim, you agree to us using and disclosing your information as set out above.

This consent to the use and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice.

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold about you is accurate, complete and up-to-date.

I agree that a photostat copy of this document shall be considered as effective and valid as the original and specifically authorised its use as such.

Name (please print): _____

Signed: _____

Date: / /

Must be completed by the injured Member/Athlete or their guardian if the Member/Athlete is under 18 years

Electronic Banking Details (to be completed by the injured person)

Please Provide Account Details to ensure prompt payment of your benefits.

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Bank Name:

Branch Address:

Account in the Name of:

Type of Account:

BSB Number: ☐☐☐ – ☐☐☐

Account Number:

Conditions of this agreement:

- I/We hereby authorise all future payments to be made via electronic funds transfer to the above bank account.
- I/We will be responsible for notifying Gallagher and/or the insurer in writing of any changes in the above particulars. Until receipt of such notifications, Gallagher and/or the insurer shall process all payments in accordance with the above particulars.
- I/We warrant that the bank account details so provided are not false and comply with all applicable laws.
- Gallagher and/or the insurer has the right to accept the authority of the undersigned as conclusive evidence of that persons authority to execute this agreement on behalf of the supplier. Gallagher and/or the insurer is under no obligation to verify the authority of the undersigned on the Bank Account details.
- I/We acknowledge that it is not practicable for Gallagher and/or the insurer to keep banking details confidential, to the extent that these will be available to Gallagher and/or the insurer in carrying out their normal duties in paying accounts.
- Gallagher and/or the insurer will not be responsible for any delays in the payment of errors due to factors outside the reasonable control of Gallagher and/or the insurer (including but not limited to delays and errors in the banking system).
- Gallagher and/or the insurer reserves the right at any time to terminate or suspend this direct credit payment method and to pay by cheque or any other manner which Gallagher and/or the insurer may determine.

Name (please print):

Signed:

Date: / /

PERSONAL INFORMATION PROTECTION STATEMENT

Personal information we collect from you on this Electronic Funds Transfer Form will be used by Gallagher staff for the purpose of making payments to you in respect of your claim. Your personal information will be used for the primary purpose for which it is collected, and will not be disclosed to third parties. Your personal information will be managed in accordance with the National Privacy and Data Protection Act 2014.

Medical Practitioners Statement to Company

Please note: Any charge issued for completion of this form will not be reimbursed, by the insurer.

This form should be completed and returns to proclaim promptly.

Patient's full name:

Date of Birth: / /

Height: cms

Weight: kgs

Diagnosis

(if fracture or dislocation, describe nature and location i.e. simple, compound)

If available please provide a copy of X-ray report

Is this injury an:

☐ Injury, or ☐ Illness

Does the patient have any other injury or illness that is contributing to the condition?

☐ Yes ☐ No

If 'Yes' give details:

Is condition due to injury or sickness arising out of the patients employment?

☐ Yes ☐ No

If 'Yes' give details:

Was the disability sport related?

☐ Yes ☐ No

If 'Yes' give details:

Date of onset / first symptoms: / /

When did the patient first consult you for this condition? / /

Has the patient ever had the same or similar condition?

☐ Yes ☐ No

If 'Yes' give details:

Has the patient had surgery or is it anticipated?

☐ Yes ☐ No

If 'Yes' give details:

Date performed or anticipated: / /

Name of hospital:

Did you provide other medical services (including pathology) to the patient?

☐ Yes ☐ No

If 'Yes', please itemise and give details:

Date: / /

Date: / /

Date: / /

Was the patient referred by you or to you?

☐ Yes ☐ No

Please provide name and address or referring doctor:

Name:

Address:

Date of referral: / /

Is the patient still disabled?

☐ No When did the patient return to work? / /

☐ Yes How long will the patient be:

☐ Totally disabled (unable to perform any part of their occupation)

from: / / to : / /

☐ Partially disabled (unable to perform any part of their occupation)

from: / / to : / /

If partially disabled, what duties could the patient perform and for how many hours a week?

Hours per week:

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, sports body or any other insurance body?

☐ Yes ☐ No

If 'Yes', give details:

Name of company and claim number:

Contact name and telephone number:

Remarks

Signature: Date: / /

Name of Doctor *(please print)*:

Qualifications:

Address:

Phone number:

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. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
3. 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.
4. 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)

5. If you are self-employed have your accountant complete 'Your Employment Details' and supply us with a copy of your last tax assessment.
6. 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.
7. 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 our office within 30 days of your injury. Do no wait for all your medical accounts. Forward them to us as you receive them.**
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 Gallagher. 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 Gallagher web site at www.ajg.com.au or telephone 1800 240 432.

Claims handling

Claims are processed at Gallagher Sporting Claims. To maximize claims handling efficiency send your completed claim form and documentation direct to that address.

Email: sport@ajg.com.au

Post:
Gallagher Sporting claims
PO Box 1898, North Sydney, NSW 2060

Gallagher

KARTING AUSTRALIA