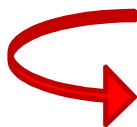




# PERSONAL INJURY CLAIM FORM



**Completed claim forms must be sent to;**

**Corporate Services Network**

GPO Box 4276

Sydney NSW 2001

Phone: (02) 8256 1770 Fax: (02) 8256 1775

Email: [liberty@csnet.com.au](mailto:liberty@csnet.com.au)



# NETBALL AUSTRALIA SUMMARY OF INSURANCE COVER

## What is Covered?

The Netball Australia National Risk Protection Insurance Personal Accident Insurance Program, which extends to cover Netball ACT, Netball NSW, Netball NT, Netball QLD, Netball SA, Netball TAS, Netball VIC and Netball WA, provides cover for a number of policy benefits. Please refer to the V-Insurance Group Netball Australia website to view the Product Disclosure Statement with full terms and conditions.

The most commonly claimed sections of the Netball Australia Personal Accident policy are reimbursement of Non Medicare Medical expenses and Loss of Income cover.

### Important Information

The Health Insurance Act (Cth) 1973 is Federal Government Legislation which does not permit the insurer to contribute to any charges covered, or partially covered by Medicare. Sometimes, your Doctor, specialist or surgeon may charge more than the Medicare rebate, which may leave you with out of pocket expenses. This is commonly called the "Medicare Gap". The Medicare Gap is not covered by the Netball Australia Insurance Program due to Government Legislation.

Please refer to the table below for some common examples:

Non-Medicare Medical Items; claimable as per the Personal Accident policy wording	Items covered by Medicare; not claimable through the Personal Accident Policy
Ambulance	Doctor
Physiotherapist	Public Hospitals
Dental	Surgeon & Surgeon's Assistant
Private Hospital Accommodation	X-Rays
Chiropractor	Anaesthetist
MRI Scans*	MRI Scans*
*MRI scans are generally covered through Medicare; however please check with your treating physician, as sometimes the provider is not registered with Medicare.	

## What are the Policy Benefits for Non Medicare Medical and Loss of Income

The following table outlines the policy benefits applicable for Non Medicare Medical and Loss of Income under the Netball Australia Insurance Program;

Non-Medicare Medical	Benefit
If you have Private Health Insurance	Reimbursement of 75% up to \$2,500 per injury for members / players (\$5,000 for officials and volunteers) \$Nil excess
If you do not have Private Health Insurance	Reimbursement of 75% up to \$2,500 per injury for members / players (\$5,000 for officials and volunteers) 100% cover for ambulance only up to \$2,500 for members / players and \$5,000 for officials and volunteers \$75 excess
Loss of Income	Benefit
If as a result of your injury you are prevented from working in your occupation a Loss of Income benefit may apply	85% reimbursement up to a maximum of \$250 per week (except Netball WA which is \$300 per week) (members / players). Higher limits apply for officials / volunteers. 14 day excess, 104 week benefit period

## Important Notes

This insurance cover is underwritten by:

Liberty Mutual Insurance Company, Australia Branch ABN 61 086 083 605; AFSL No. 530842 (for claims handling and settling services only), a company incorporated in Massachusetts, USA (the liability of members is limited), trading as Liberty Specialty Markets

Claims are managed by:

Corporate Services Network (CSN, AR No. 001294637) as Authorised Representative of Gallagher Bassett Services Pty Ltd (AFSL No. 530867)

1. This summary of cover provides factual information about the Netball Australia Insurance Program.
2. This information is only a summary of the cover provided. The policy with full conditions is available at [www.vinsurancegroup.com/netballaustralia](http://www.vinsurancegroup.com/netballaustralia) or available by contacting Netball Australia.
3. This insurance program commences on 1 February 2022 and expires on 1 February 2023.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Netball Australia who, through injury or accident, incur financial loss and who would otherwise not have received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
5. Netball Australia is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

## HOW TO MAKE A CLAIM

Dear Netball Australia member,

A Personal Accident Claim Form (**Claim Form**) is attached at page 5. Before lodging the Claim Form, please ensure all sections are fully completed. Failure to complete all sections of the Claim 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 pages 5 & 6 and sign and date the Declaration.
3. Please ensure that your Association/Club official completes and signs the Association/Club Declaration on page 5.
4. If you intend to claim for Loss of Income:
  - a) You and your employer/salary office must complete page 8. If self-employed your accountant must complete these details;
  - b) You **must** complete the Tax File Declaration form on page 9. If you are employed and pay tax on the income you earn (known as PAYE), the Australian Tax Office (**ATO**) requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be forwarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.
  - c) Have your Attending Physician or Physiotherapist complete the page titled "Doctor's Statement" on page 11.
5. For claims involving Non-Medicare medical expenses:
  - a) Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).
  - b) Have your Attending Physician complete the "Attending Physician" statement on page 11.
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 the insurer to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital bed and theatre fees, 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 have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.
8. Please forward the entire form with supporting documentation to Corporate Services Network. They handle all claims for the insurer. Their contact details are as follows;

**Corporate Services Network**  
**GPO Box 4276**  
**SYDNEY NSW 2001**  
**Phone (02) 8256 1770**  
**Fax (02) 8256 1775**  
**Email [liberty@csnet.com.au](mailto:liberty@csnet.com.au)**

9. Your reimbursement payment will be made by Corporate Services Network by direct deposit or cheque.
10. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network (Claims Services) can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.
11. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance Group Team on (02) 8599 8660 or 1300 945 547.

# PERSONAL ACCIDENT CLAIM FORM

## CLAIMANT DETAILS

Association Name(compulsory):  Club Name:	Member No (if applicable):	Claimant's Given Name:  Surname:
Name of team/age group/grade:		
Gender please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth:    /    /
Address	State	Postcode
Phone Number (work): (    )		Home: (    )
Please tick the category applicable <input type="checkbox"/> Player <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Umpire <input type="checkbox"/> Other		Email:
If Other, please advise _____		

## DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I \_\_\_\_\_(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Liberty Specialty Markets to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information Liberty Specialty Markets and their service providers in order to assess the claim. Liberty Specialty Markets complies with the obligations of the Privacy Act 1998 (Cth) and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_  
(or Legal Guardian if under 18 years of age)

## DECLARATION BY ASSOCIATION/CLUB

Name of Association/Club:	Name of Association/Club Official making this statement:
Official Position:	Telephone Number: (    )
Email:	
Address	State    Postcode
I, the above mentioned Netball Australia Club Official, confirm that the claimant was a registered and Financial member of this Netball Australia Club and was an insured person as identified in the Personal Accident Insurance with Liberty Specialty Markets at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.	
Do you have any comments in relation to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please detail below _____	
Dated:    /    /	Signature of Association/Club Official:

## ACCIDENT DETAILS

Describe the accident and how it happened? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe your injury?

When did your accident occur?

Date:    /    /                      Time:                      am/pm

Was your activity at the time of the accident? (please tick)	Officially organised competition	<input type="checkbox"/>
	Officially organised training	<input type="checkbox"/>
	Social or private competition	<input type="checkbox"/>
	Travelling to and from activity	<input type="checkbox"/>
	Sanctioned fundraising/social event	<input type="checkbox"/>

What type of Netball activity were you participating in? (please tick)	Netball Association / Club Activity	<input type="checkbox"/>
	Fast 5 Netball	<input type="checkbox"/>
	NetFest	<input type="checkbox"/>
	Social Netball Training / Competition	<input type="checkbox"/>

Please provide the address of where the injury occurred?

State the name of any one witness to the injury:	Address of Witness:
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Person to whom accident/incident was reported?	Date and time reported? Date:    /    /                      Time:                      am/pm
--	--

Brief summary of treatment/action taken at the time of the accident/incident?

Was hospitalisation required?	If yes, please advise the name of hospital?
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If admitted into hospital, how long were you there?	Name of person who gave treatment?
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Do you have Private Health Insurance?	If yes, please give fund name?
---------------------------------------	--------------------------------

Advise when you did (or expect to):	Cease work/normal activities	_____
	Cease training	_____
	Cease participating	_____
	Resume work/normal activities	_____
	Resume training	_____
	Resume participating	_____

Have you ever had this injury or similar injuries in the past? Yes/No	If yes, please advise when?    /    /
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The following information is required for Netball Australia research to assist with Risk Management, answering these questions will not affect your claim

Where did your injury occur? (please tick)	Indoor	<input type="checkbox"/>
	Outdoor	<input type="checkbox"/>
Surface at point of injury? (please tick)	Timber	<input type="checkbox"/>
	Synthetic	<input type="checkbox"/>
	Concrete / Asphalt	<input type="checkbox"/>
	Other, please advise.....	<input type="checkbox"/>
Weather conditions? (please tick)	Fine	<input type="checkbox"/>
	Rain	<input type="checkbox"/>
	Showers	<input type="checkbox"/>
	Extreme Heat	<input type="checkbox"/>
	Extreme Cold	<input type="checkbox"/>
Surface Conditions? (please tick)	Wet	<input type="checkbox"/>
	Dry	<input type="checkbox"/>
	Other, please advise.....	<input type="checkbox"/>
Quarter/half injured? (please tick)	1 <sup>st</sup> Quarter	<input type="checkbox"/>
	2 <sup>nd</sup> Quarter	<input type="checkbox"/>
	3 <sup>rd</sup> Quarter	<input type="checkbox"/>
	4 <sup>th</sup> Quarter	<input type="checkbox"/>
	Not applicable	<input type="checkbox"/>

# LOSS OF INCOME

YOU MUST COMPLETE THIS SECTION & THE TAX FILE NUMBER DECLARATION FORM IF YOU ARE CLAIMING FOR LOSS OF INCOME

(please tick 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 \$..... <small>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.</small>	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 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the employee lodged or intending to lodge a Workers Compensation Claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature:	Date: / /
Company Stamp:	ABN/ACN:

## B. IF SELF EMPLOYED

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





**DECLARATION by payer:** I declare that the information I have given is true and correct.

Signature of payer

Date  
Day                      Month                      Year

--	--	--	--	--	--	--	--	--	--

There are penalties for deliberately making a false or misleading statement.

**6 If you no longer make payments to this payee, print X in this box.**

Return the completed original ATO copy to:  
Australian Taxation Office  
PO Box 9004  
PENRITH NSW 2740

**! IMPORTANT**  
**See next page for:**  
■ payer obligations  
■ lodging online.



30920716

**Sensitive** (when completed)



AR No. 432898 Willis Australia Limited AFSL: 240600  
 Phone (02) 8599 8660 or local call cost only 1300 945 547  
 Completed claim forms should be sent to  
 Corporate Services - [liberty@csnet.com.au](mailto:liberty@csnet.com.au),  
 GPO Box 4276, Sydney NSW 2001

## SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

### IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.
3. If "Yes" answered to any of the following, please give details.
4. Dashes or blank spaces are not acceptable.

### TO BE COMPLETED BY THE ATTENDING PHYSICIAN/PHYSIOTHERAPIST

Patient's Full Name:

How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?     /     /

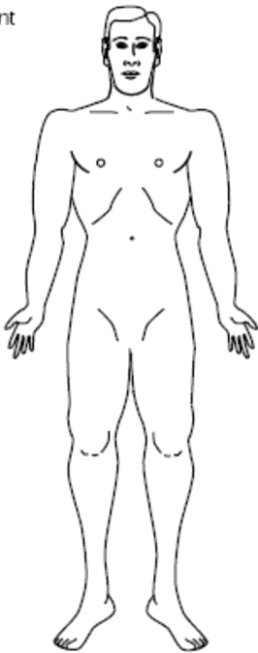
Patient's Occupation:

Are you the patient's regular general practitioner?      Yes      No

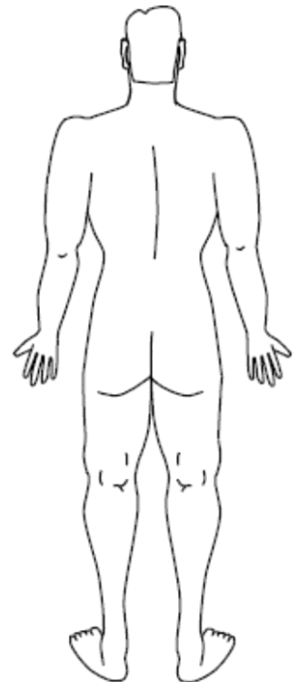
If not, please advise who is .....

What is the exact nature of the present injury?

Front



Back



Head





## 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  Ms  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: \_\_\_\_\_

## DECLARATION BY CLAIMANT (OR GUARDIAN IF CLAIMANT UNDER 18)

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty using and disclosing my personal information pursuant to their Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## PRIVACY NOTICE

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at [privacy.officer.ap@libertyglobalgroup.com](mailto:privacy.officer.ap@libertyglobalgroup.com) or call +61 2 8298 5800 and/or CSN's Privacy Officer at [privacy@csnet.com.au](mailto:privacy@csnet.com.au) or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website ([libertyspecialtymarkets.com.au](http://libertyspecialtymarkets.com.au)) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website ([csnet.com.au](http://csnet.com.au)) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

## MEDICAL AUTHORITY

By executing the declaration I consent to CSN or Liberty using and disclosing my personal and any sensitive information obtained through this document and for the purpose of assessing my claim including any entitlement to benefits under the policy, or the health and safety evaluation of the sport of Netball, including disclosing such information to Netball Australia (including any subsidiary bodies) and Netball Australia's insurance agent pursuant to their Privacy Policies.

I authorise any person or entity, including any hospital and / or physician who has treated me, to provide to CSN or Liberty such personal or sensitive information (including medical records, my past medical history or other health information) as CSN or Liberty in their absolute discretion consider necessary for their assessment of my claim or my entitlement to benefits.