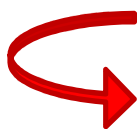




# PERSONAL INJURY CLAIM FORM



**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: [claims@csnet.com.au](mailto:claims@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 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 Specialty Risks

ABN 61 086 083 605

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 2020 and expires on 1 February 2021
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,

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 are able to do so. The claim form should be completed and submitted as soon as you are able to do so. The claim form should be completed and submitted as soon as you are able to do so.
2. 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 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.
3. 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 [claims@csnet.com.au](mailto:claims@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 ph: (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: (    )
Mobile:		
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 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 Risks 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 Risks and their service providers in order to assess the claim. Liberty Specialty Risks complies with the obligations of the Privacy Act 2001 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 Risks 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?     Yes     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:
--	---------------------

Person to whom accident/incident 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?
-------------------------------	---

If admitted into hospital, how long were you there?	Name of person who gave treatment?
---	------------------------------------

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?    /    /
---	---------------------------------------

**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:	





Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
Print X in the appropriate boxes.
Read all the instructions including the privacy statement before you complete this declaration.

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 2, 4b)

ato.gov.au

Section A: To be completed by the PAYEE

1 What is your tax file number (TFN)?

Grid for tax file number (TFN)

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN.

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax.

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance.

2 What is your name? Title: Mr Mrs Miss Ms

Surname or family name

First given name

Other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

Grid for previous family name

4 What is your date of birth? Day Month Year

Grid for date of birth

5 What is your home address in Australia?

Grid for home address line 1

Grid for home address line 2

Suburb/town/locality

Grid for suburb/town/locality

State/territory Postcode

Grid for state/territory and postcode

Once section A is completed and signed, give it to your payer to complete section B.

Section B: To be completed by the PAYER (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number? Branch number (if applicable)

Grid for ABN and branch number

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes No

3 What is your legal name or registered business name (or your individual name if not in business)?

Grid for legal name

C O R P O R A T E S E R V I C E S

Grid for legal name

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 On what basis are you paid? (Select only one.)

Full-time employment Part-time employment Labour hire Superannuation or annuity income stream Casual employment

7 Are you an Australian resident for tax purposes? (Visit ato.gov.au/residency to check)

Yes No

8 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold. Answer no here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Complete a Withholding declaration (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions.

10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Complete a Withholding declaration (NAT 3093).

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment.

(b) Do you have a Financial Supplement de

Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment.

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

Signature

You MUST SIGN here Date Day Month Year

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

4 What is your business address?

Grid for business address line 1

Grid for business address line 2

Suburb/town/locality

Grid for suburb/town/locality

State/territory Postcode

Grid for state/territory and postcode

5 Who is your contact person?

A N T H O N Y R O U H A N A

Business phone number 0 2 8 2 5 6 1 7 7 0

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)

# NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

Are you a member of an Ambulance Service?  Yes  No

Are you a member of a Private Health Fund?  Yes  No

If yes, please provide details .....

Hospital Cover?  Yes  No

Extras covering Physio etc  Yes  No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
				<b>Total</b>	
				<b>Less Excess</b>	
				<b>TOTAL AMOUNT OF CLAIM</b>	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor:.....

Address:.....

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 - [claims@csnet.com.au](mailto:claims@csnet.com.au),  
 GPO Box 4276, Sydney NSW 2001

## SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

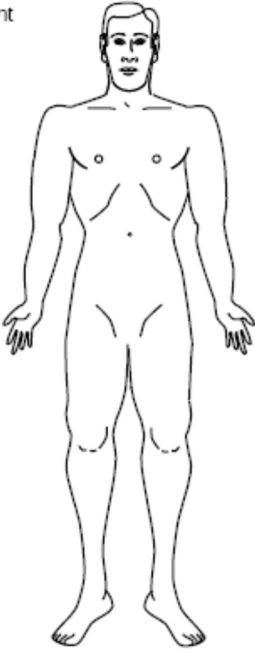
**IMPORTANT**

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.**

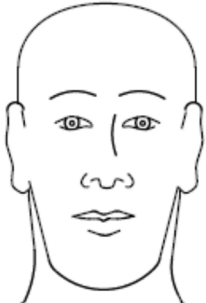
**TO BE COMPLETED BY THE ATTENDING PHYSICIAN/PHYSIOTHERAPIST**

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, please advise who is .....	
What is the exact nature of the present injury?	

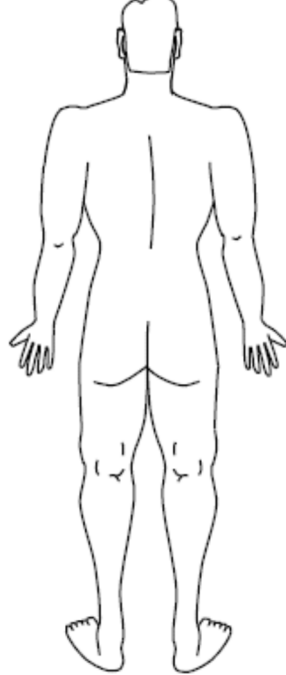
Front



Head



Back





## 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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Nominated account name: \_\_\_\_\_

Bank, Credit Union, Building Society name: \_\_\_\_\_

Branch: \_\_\_\_\_

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

I hereby authorise Corporate Services Network as agents of Liberty Specialty Risks to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment.
- Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network's disclosure of this information, to Corporate Services Network's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988*. I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.
- I agree that my personal information may also be shared with Netball Australia's insurance brokers, V-Insurance Group.

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

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

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