V-INSURANCE GROUP

Office use only

Claim Number: _____

AUSCYCLING

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

V-INSURANCE GROUP

INSURANCE BROKER FOR AUSCYCLING;

Authorised Representative No. 432898 a corporate authorised representative of Willis Australia Limited AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547

Important Notes

This insurance cover is issued by:

360 Accident & Health Pty Ltd
ABN 18120 261 270
Suite 3, Level 18, 201 Kent Street,
Sydney, NSW, 2000

1. This summary of insurance cover provides factual information about the AusCycling Insurance Program as contained in the Product Disclosure Statement (PDS). Cover is subject to the full terms, conditions and exclusions contained in the PDS. Certain terms used in this summary are defined in the PDS.
2. In the event that your claim is accepted, PAYG tax will be deducted from weekly or fortnightly benefit payments made to you by Certain underwriters at Lloyd's of London in accordance with the Tax Administration Act 1953.
3. This insurance program commenced on 30 November 2020 and expires on 31 May 2022.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of AusCycling who, through injury or accident, incur financial loss and who would not have otherwise 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. AusCycling are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the AusCycling insurance program can be obtained by visiting
www.vinsurancegroup.com/auscycling

HOW TO MAKE A CLAIM

Dear AusCycling member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed as truthfully and accurately as possible. 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 in order to lodge your claim form.

2. Please ensure that you fully complete pages 4, 5 & 6 and sign and date the Declarations.

3. For claims involving Loss of Income:

a) You must complete pages 6 and 7 and have your employer/salary officer complete pages 6 and 7. If self employed, you must have your accountant complete these details;

b) You must complete the Tax File Declaration form on page 8. 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.

c) Have your Attending Physician or Physiotherapist complete the page titled “Doctor’s Statement” on pages 11 and 12.

4. 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 12.

5. 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.

6. Once you have completed your claim form, please forward with all relating documentation and receipts to AusCycling at the following address;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone: (02) 8256 1770
Fax: (02) 8256 1775
Email: claims@csnet.com.au

7. Your reimbursement cheque or payment will be sent to you directly by Corporate Services Network. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network can also be reached on (02) 8256 1770 should you wish to make enquiries relating to the progress of your claim.

8. 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

Claimant's Given Name:		Surname:	
Name of Club: (only applicable if claimant is a member of a Club)	Age Group/Grade: (only applicable if accident occurred during a race/competition)		Member No: Member Type (please tick one): Race: ❑ Recreation: ❑ Day Licence: ❑ Free Trial: ❑ Non-Riding: ❑
Occupation:	Date of Birth: / /	Gender (please tick): ❑ Male ❑ Female	Email:
Address: State: Postcode:			
Phone Number - Work: ( )	Home: ( )		Mobile: ( )

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 360 Accident and Health Pty Ltd 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 by 360 Accident and Health Pty Ltd and their service providers in order to assess the claim. 360 Accident and Health Pty Ltd 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)

ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury? _____

_____

When did your accident occur?
Date: / / Time: _____ am/pm

What was your activity at the time of the accident? (please tick)

- Officially organised competition ❑
- Club Training ❑
- Training for event ❑
- Social riding ❑
- Commuting ❑
- Travelling to and from activity ❑
- Sanctioned fundraising/social event ❑

Other: _____

At the time of the accident were you riding a:

- BMX ❑
- Mountain Bike ❑
- Road Bike ❑

If other, please state _____

If your accident occurred whilst you were competing in any other event, please provide the name of the event?

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 was reported?	Date and time reported? Date: / / Time:_____ am/pm

Brief summary of treatment/action taken at the time of the accident:

Was hospitalisation required? ❑ Yes ❑ No	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? ❑ Yes ❑ No	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?	If yes, please advise when: / /

The following information is required for AusCycling research to assist with Risk Management.
Answering these questions will not affect your claim.

Surface at point of injury? (please tick)	Road	❑
	Bike Path	❑
	Dirt/Gravel	❑
	Velodrome	❑
	Other: _____	
Weather conditions? (please tick)	Fine	❑
	Rain	❑
	Showers	❑
	Extreme Heat	❑
	Extreme Cold	❑

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

B. IF SELF EMPLOYED

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

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

Extra's 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 eg Dental, Physiotherapy etc	Date of Service	Charge	Private Health Fund Recovery (if applicable)	Amount Claimable
				Total	
				Less Excess	
				Total Amount of Claim	

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

Name of Doctor:.....

Address:.....

Australian Government
Australian Taxation Office

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 3, 4b)

ato.gov.au

Section A: **To be completed by the PAYEE**

1 What is your 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.

4 What is your date of birth? Day / Month / Year

5 What is your home address in Australia?

Suburb/town/locality

State/territory Postcode

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.

Yes ☐ **No** ☐ 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?

Yes ☐ 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. **No** ☐

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?

Yes ☐ Complete a *Withholding declaration* (NAT 3093). **No** ☐

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

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. **No** ☐

(b) Do you have a Financial Supplement de

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. **No** ☐

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.

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?

30 074 864 609

Branch number (if applicable) 004

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)?

CORPORATE SERVICES

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.

4 What is your business address?

Suburb/town/locality

State/territory Postcode

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 02 8256 1770

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)

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: _____

Branch:_____

DECLARATION

I hereby authorise Corporate Services Network Pty Ltd 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.

Signature _____ Date: _____

Print Name_____

TO BE COMPLETED BY THE CLAIMANT

Privacy Statement

Corporate Services Network is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). Corporate Services Network will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs. 360 Accident & Health Pty Ltd will take all reasonable steps to ensure that personal information held by Corporate Services Network is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

Corporate Services Network has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information.

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770.

Medical Authority And Declaration

I understand that by investigating my claim or by accepting proof of my claim, Corporate Services Network has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Corporate Services Network using and disclosing my personal information pursuant to Corporate Services Nework's 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 Corporate Services Network's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to Corporate Services Network such personal information (including health information) as Corporate Services Network 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 Corporate Services Network 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, Corporate Services Network may not be able to process or assess my claim.

I appoint Corporate Services Network 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.

I agree that my personal information may also be shared with AusCycling's insurance brokers, V-Insurance Group.

Signature of Claimant:		Dated:	
Name of Claimant:			
Signature of Witness:		Dated:	
Name of Witness:			

Authorised Representative No. 432898
a corporate authorised representative of
Willis Australia Limited AFSL: 240600
Level 25, 123 Pitt Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547

Office use only
Claim Number: _____

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT
(PLEASE PRINT LEGIBLY)

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can only be completed by the treating Doctor / Specialist Doctor.**
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

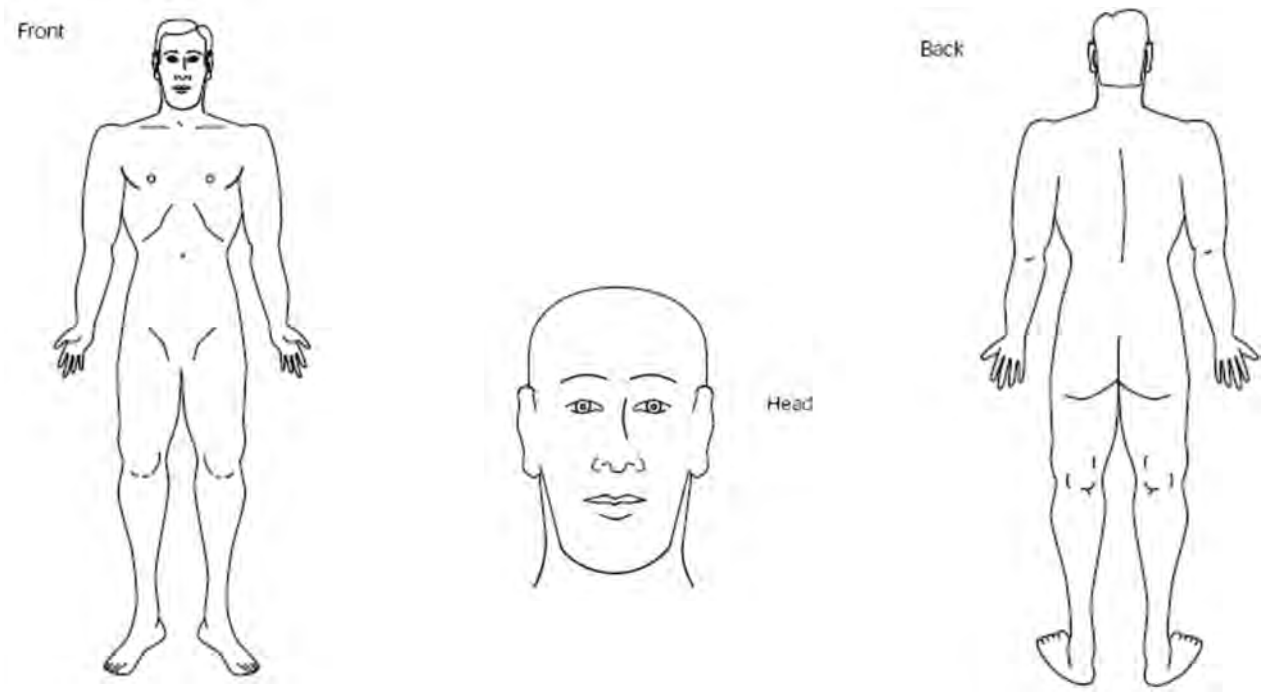
Patient's Full Name:	How long have you known the patient?

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

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?



Do you consider the patients injury to be a new injury? ❑ Yes ❑ No

A recurrence of an old injury? ❑ Yes ❑ No

If yes, please state condition and advise when previous treatment was given.....

.....

Have you referred the patient to any other services or treatment? ❑ Yes ❑ No

Please specify the type and approximate number of treatments required:

❑ Physiotherapy .....

❑ Chiropractic .....

❑ Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated? .....

Are there any further remarks which may assist in assessing this condition? .....

.....

Is there any permanent disability at present? ❑ Yes ❑ No

If yes, please explain giving estimated percentage loss of function .....

.....

Was the patient obliged to cease work? ❑ Yes ❑ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to Cycling? .....

Does the patient have any congenital defects or chronic diseases? ❑ Yes ❑ No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted Date Released

/ / / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....