V-INSURANCE GROUP

Office use only
Policy Number: 08VW631411
Claim Number: _____

BASKETBALL WESTERN AUSTRALIA

Basketball WA

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

DWF Claims Management
Locked Bag 32012
Collins Street East VIC 8003
Phone (02) 9287 1302
Fax (02) 1 300 858 329
Email ausclaimsah@dwfgroup.com

V-INSURANCE GROUP

INSURANCE BROKER FOR BASKETBALL WA;
Authorised Representative No. 432898 a corporate authorised representative of MGA Insurance Brokers Pty Ltd
AFSL: 244601

Phone +61 (2) 8599 8660 or 1300 172 321

BASKETBALL WA
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $100,000 for members aged 18-65 or $20,000 for persons under 18 years old or over 65 years old.

Non Medicare Medical Expenses

Reimburses up to 75% of Non-Medicare medical expenses up to a maximum of $2,000 ($5,000 for Volunteers) with Ambulance Transport Costs reimbursed up to $500. Claimable expenses are private hospital bed and theatre fee, ambulance, dental, physiotherapy etc, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or $50 for claimants who do not have private health insurance. Cover is limited to expenses incurred within 12 months from the date of injury.

Student Tutorial Costs

Reimburses up to 80% of costs incurred up to a maximum of $200 per week for home tuition by a qualified tutor if the Injury stops the Insured Person from going to their external tutor outside the home for up to 52 weeks.

Domestic Help Benefit

Reimburses up to 80% of costs incurred up to a maximum of $200 per week for a recognized and licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependant children such as child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 7 day excess period

Loss of Income

Weekly Benefit 100% of earnings, if prevented from working in your occupation up to a maximum of $250 per week ($700 per week for Volunteers). The benefit period is 52 weeks and the excess is 7 days.

Funeral Benefit

We will pay up to an additional $10,000 for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

Important Notes

This insurance cover is underwritten by:- Chase Underwriting
Level 1, 68 Clarke Street
Southbank VIC 3006

1. This summary of cover provides factual information about the Basketball WA Insurance Program.
2. This information is only a summary of the cover provided. The policy with full conditions is available at www.vinsurancegroup.com/basketball or by contacting Basketball WA.
3. This insurance program commences on 1 September 2025 to 1 September 2026.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Basketball WA 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. Basketball WA is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

Further details on the Basketball WA insurance program can be obtained by visiting

www.vinsurancegroup.com/basketball

HOW TO MAKE A CLAIM

Dear Basketball WA 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 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 4, 5, & 6 and sign and date the Declaration.
3. For claims involving Loss of Income:
   a) You must complete page 7 and have your employer/salary officer complete page 7. If self-employed, you must have your accountant complete these details;
   b) You must attach at least two payslips including the most recent full period pre-Injury.
   c) You must complete the Tax File Number 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 fowarded 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.
   d) Have your Attending Physician complete the page titled “Doctor’s Statement” on page 11. This may be completed by a Physiotherapist for minor injuries only.
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 or dentist).
   b) Have your Attending Physician complete the “Attending Physician” statement on pages 10 & 11.
5. Please attach all itemised receipts (be sure to copy them before you claim with your health fund as they will retain the original). Hospital claims must be accompanied by an itemised Invoice, not just the estimate. 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 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.
7. Once you have completed your claim form, please forward to DWF Claims Management. They handle all claims for the insurer.

   DWF Claims Management
   Locked Bag 32012 Collins Street East VIC 8003
   Phone +61 2 9287 1302
   Fax 1 300 858 329
   Email ausclaimsah@dwfgroup.com

8. Reimbursement will be paid to you directly by DWF Claims Management by deposit into your nominated bank account.
9. Once your claim is registered, you can submit ongoing receipts via DWF Claims Management. DWF Claims Management can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.
10. If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the V-Insurance Group Team on ph: +61 (2) 8599 8660 or 1300 172 321.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Association Name(compulsory):	Member No (if applicable):	Club Name:
Claimant's Name:		
Name of team/age group/grade:		
Gender (please tick): ☐ Male ☐ Female	Occupation:	Date of Birth: / /
Address		State Postcode
Email:		
Phone Number (Work): ( )		Home: ( )
Mobile Number:		

Please tick the category applicable ☐ Player ☐ Official ☐ Coach ☐ Umpire ☐ 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 Chase Underwriting and their claims managers, DWF Claims Management, 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 Chase Underwriting and their service providers in order to assess the claim. Chase Underwriting 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)

Name of Guardian: _____

DECLARATION BY ASSOCIATION

Name of Association/Club:	Name of Association/Club Official making this statement:
Official Position:	Telephone Number: ( ) Email:
Address	State Postcode

I, the above mentioned Basketball WA Club Official, confirm that the claimant was a registered and member of this Basketball WA club and was an insured person as identified in the Personal Accident Insurance with Chase Underwriting 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 how the accident 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 ☐
	Officially organised training ☐
	Social or private competition ☐
	Travelling to and from activity ☐
	Sanctioned fundraising/social 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 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?

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 (similar injuries) in the past? ☐ Yes ☐ No	If yes, please advise when?

The following information is required for Basketball WA research to assist with Risk Management, answering these questions will not affect your claim		
Where did your injury occur? (please tick)	Indoor	☐
	Outdoor	☐
What type of team were you playing in?	Women's	☐
	Men's	☐
	Mixed	☐
	Youth	☐
Surface at point of injury? (please tick)	Timber	☐
	Synthetic	☐
	Concrete / Asphalt	☐
	Other, please advise	☐
	.....	
Weather conditions? (please tick)	Fine	☐
	Rain	☐
	Showers	☐
	Extreme Heat	☐
	Extreme Cold	☐
Surface Conditions? (please tick)	Wet	☐
	Dry	☐
	Other, please advise	☐
	.....	
Quarter injured? (please tick)	1st Quarter	☐
	2nd Quarter	☐
	3rd Quarter	☐
	4th Quarter	☐
	Not applicable	☐

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 including Loss of Income?	☐	☐
2. Have you ever made any previous claims in respect to personal accident insurance or any other similar 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: ( ) Email:
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: Average Gross Base Salary $..... Per week Base salary, exclusive of overtime, allowances, bonuses & commissions 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: ( ) Email:
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: / /

Australian Government
Australian Taxation Office

ato.gov.au

Tax file number declaratio

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.

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

1 What is r tax fil m (TFN)?

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

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 r na e? Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname or family name

First given name

Other given names

3 What is r h e address in A stralia?

Suburb/town/lo ality

State/territory Post ode

4 If have changed r na e since you last dealt with the ATO, p ovid yo p vio s family am .

5 What is y r ri ar e- ail address?

6 What is y r date f birth? Day / Month / Year

7 On what basis are aid? (select only one)

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

8 Are you: (sele t only one)

An Australian resident for tax purposes ☐ A foreign resident for tax purposes ☐ **OR** A working holiday maker ☐

9 Do you want t clai 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 sour es for the finan ial year will be less than the tax-free threshold.

Yes ☐ **N** ☐ Answer **no** here if you are a foreign resident or working holiday maker, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

10 Do you have a Higher Education Loan Program (HELP), VET Student L an (VSL), Financial S pplement (FS), Student Start-up Loan (SSL) or Trade Suppo t Loa (TSL) debt?

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

DECLARATION b a ee: *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 complete an 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 r A stralian b siness nu ber (ABN) or withh lding a er n ber? 74 087 666 484

Branch number (if applicable) 003

2 If d n't have an ABN r withh lding a er n ber, have a lied f r one? Yes ☐ No ☐

3 What is r legal na e r registered business name (r r individ al na e if n t in business)?

PROCLAIM MANAGEMENT SOLUTIONS

4 What is r b siness address?

LOCKED BAG 32012

Suburb/town/lo ality: COLLINS STREET EAST

State/territory Post ode: 8003

What is y r ri ar e- ail address?

AHCLAIMS@PROCLAIM.COM.AU

6 Who is y r c ntact erson?

KATE ELLIS

Business phone number 0292871322

7 If you no l nger ake ay ents to this payee, print X in this box. ☐

DECLARATION b a er: *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.

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

IMPORTANT
See next page for:
- payer obligations
- lodging online.

Sensitive (when completed)

30920619

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

Itemised accounts and receipts must be submitted together with details of Benefits 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
				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:.....

V-INSURANCE GROUP

AR No. 432898 MGA Insurance Brokers Pty Ltd AFSL: 244601 Phone +61(2) 8599 8660 or 1300 172 321
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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** (Physiotherapist may complete for minor injuries only).
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

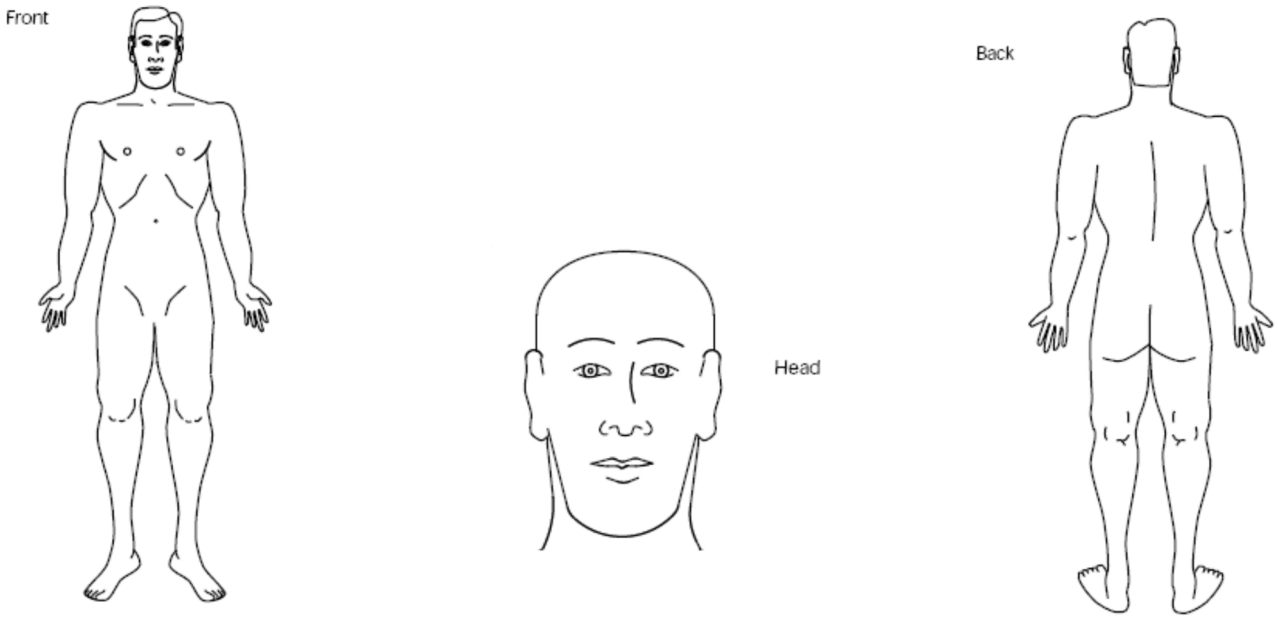
Patient's Full Name:	How long have you known the patient?

What date 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? (Please detail symptoms and diagnosis)



Do you consider the patient's 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 Yes, from ...../...../.....

If so, when do you expect the patient to resume: Some duties .....

Full duties .....

What date do you advise the patient may return to basketball? .....

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: .....

METHOD OF PAYMENT

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account

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

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Account Holder's Full name: _____

Bank, Credit Union, Building Society name: _____

Branch:_____

DECLARATION

I hereby authorise DWF Claims Management as agents of Chase Underwriting 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 DWF Claims Management has instructed its bank to credit the nominated account and that we release DWF Claims Management from any further liability in relation to this payment.
- DWF Claims Management is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to DWF Claims Management collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to DWF Claims Management disclosure of this information, to DWF Claims Management 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 Basketball Australia's insurance brokers, V-Insurance Group.

Signature: _____ Date: _____

Print Name: _____