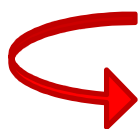


## BICYCLE NSW



## 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)



**INSURANCE BROKER FOR BICYCLE NSW;**

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

# BICYCLE NSW

## SUMMARY OF INSURANCE COVER

### Death & Permanent Disablement

The scale of benefits is defined in the policy. Members – Death Benefit (18-65 years of age) \$50,000. Death Benefit (under 18 – over 65 years of age) \$25,000. Volunteers – Death Benefit (18-65 years of age) \$100,000. The paraplegia and quadriplegia benefit is \$100,000.

### Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses up to a maximum of \$7,500. Some claimable expenses include but are not limited to are private hospital, ambulance, dental, 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 twelve (12) months from the date of injury.

### Student Assistance Benefit (Full time students)

Reimburses 100% of costs incurred up to a maximum of \$200 per week for up to 52 weeks being costs actually incurred for tutoring to assist the full-time student – 7 day excess.

### Home Help Benefit

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of \$200 per week for up to 52 weeks, being reimbursement of actual costs of hiring domestic help and/or child-minding services as a result of injury, insured by the policy – 7 day excess.

### Parents Inconvenience Allowance

Pays up to \$200 per week of non medical expenses such as transportation and accommodation costs. This benefit is only available for full time students under 25 years of age. The maximum benefit period is 52 weeks.

### Loss of Income

Cover for 85% of your net weekly income or up to a maximum of \$1,000 per week, whichever is the lesser. The benefit period is 52 weeks and the excess is 14 days.

### Important Notes

This insurance cover is issued by:- Blend Insurance Solutions

1. This summary of insurance cover provides factual information about the Bicycle NSW insurance program.
2. The policy with full terms, conditions and exclusions is available at <http://www.vinsurancegroup.com/bicyclensw> or by contacting Bicycle NSW.
3. This insurance program commenced on 1 July 2020 and expires on 1 July 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Bicycle NSW 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. Bicycle NSW 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 Bicycle NSW insurance program can be obtained by visiting**

<http://www.vinsurancegroup.com/bicyclensw>

# HOW TO MAKE A CLAIM

Dear Bicycle NSW 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 to lodge your claim form.
2. Please ensure that you fully complete pages 4 & 5 and sign and date the Declaration.
3. For claims involving Loss of Income:
  - a) You must complete page 6 and have your employer/salary officer complete page 6. If self employed, you must have your accountant complete these details;
  - b) You must complete the Tax File Declaration form on page 7. 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 9 and 10.
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 pages 9 & 10.
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 Bicycle NSW;

**Corporate Services Network**

GPO Box 4276  
Sydney NSW 2001  
Phone +61 2 8256 1770  
Fax +61 2 8256 1775  
Email [claims@csnet.com.au](mailto:claims@csnet.com.au)

7. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network (either by email [claims@csnet.com.au](mailto:claims@csnet.com.au) or post to GPO Box 4276, Sydney NSW 2001). Should you wish to make enquiries relating to the progress of your claim please contact Corporate Services Network directly.
8. 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 (02) 8599 8660 or 1300 945 547.

# PERSONAL ACCIDENT CLAIM FORM

|   |                       |  |          |
|---|-----------------------|--|----------|
| Claimant's Given Name:  |                       | Surname:   |          |
| Age group/grade:  |                       | Member No<br>(if applicable):  |          |
| Occupation:   | Date of Birth:<br>/ / | Gender (please tick):<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Email:   |
| Address   |                       | State  | Postcode |
| Phone Number (work):<br>( )   | Home<br>( )           | Mobile   |          |
| Please tick the category applicable <input type="checkbox"/> Rider <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Other<br>If Other, please advise _____ |                       |  |          |

## ACCIDENT DETAILS

|   |   |
|---|---|
| Describe the accident and how it happened? _____<br>_____<br>_____  |   |
| Describe your injury?   |   |
| When did your accident occur?<br>Date: / / Time: am/pm  |   |
| Was your activity at the time of the accident?<br>(please tick)   | Officially organised competition <input type="checkbox"/><br>Group training <input type="checkbox"/><br>Individual training <input type="checkbox"/><br>Travelling to and from activity <input type="checkbox"/><br>Travelling to or from work <input type="checkbox"/><br>Sanctioned fundraising/social event <input type="checkbox"/><br>Bike couriering/riding for fare or reward <input type="checkbox"/><br>Other: _____ |
| 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?<br>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 _____<br>Cease training _____<br>Cease participating _____<br>Resume work/normal activities _____<br>Resume training _____<br>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 Bicycle NSW research to assist with Risk Management. Answering these questions will not affect your claim.**

|  |  |
|--|--|
| Where were you at the point of injury?<br>(please tick)    | Traffic Lights <input type="checkbox"/><br>Roundabout <input type="checkbox"/><br>Driveway <input type="checkbox"/><br>Intersection <input type="checkbox"/><br>Other: _____   |
| What time of day did your accident occur?<br>(please tick) | Early Morning (5am – 9.30am) <input type="checkbox"/><br>Mid Morning (9.30am – 12pm) <input type="checkbox"/><br>Early Afternoon (12pm – 2.30pm) <input type="checkbox"/><br>Late Afternoon (2.30pm to 5pm) <input type="checkbox"/><br>Early Evening (5pm – 8pm) <input type="checkbox"/><br>Later: _____ |
| What type of Accident? (please tick)                       | Solo <input type="checkbox"/><br>Claimant (You) hit a motor vehicle <input type="checkbox"/><br>Motor Vehicle hit claimant (You) <input type="checkbox"/><br>Another bicycle was involved <input type="checkbox"/><br>Other: _____   |
| What were the road conditions? (please tick)               | Slippery/Wet <input type="checkbox"/><br>Dry <input type="checkbox"/><br>Dirt/Gravel <input type="checkbox"/><br>Other: _____  |

## 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 Workers 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:<br>( )                       | Fax Number:<br>( )                             |
| 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:<br>Net \$ ..... Gross \$ .....<br><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:<br>/ / |  |
| Income Definition:<br><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: ABN/ACN:<br>/ / |
| Company Stamp:              |                       |

### B. IF SELF EMPLOYED

|                             |                   |
|-----------------------------|-------------------|
| Accountant's name:          | Phone Number: ( ) |
| Accountant's signature:     | Date:<br>/ /      |
| Accountant's Company Stamp: |                   |







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 Network, GPO Box 4276, Sydney NSW 2001  
 or via email claims@csnet.com.au

## 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? \_\_\_\_\_

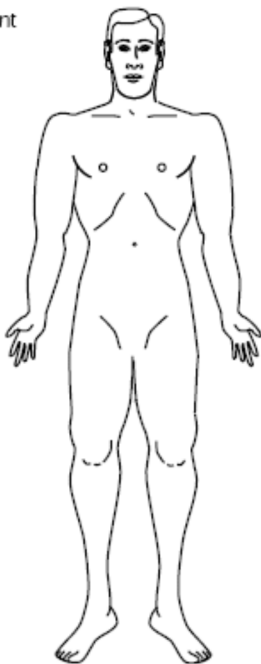
What date and where were you first consulted by the patient in connection with the present injury?     /     /

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

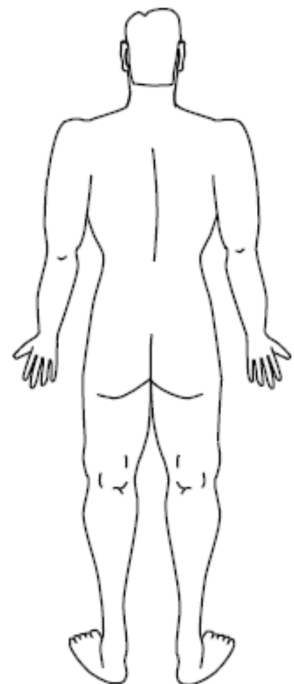
If not, please advise who is .....  
 .....

What is the exact nature of the present injury? \_\_\_\_\_  
 \_\_\_\_\_

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

I hereby authorise Corporate Services Network 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: \_\_\_\_\_