

# AUSTRALIAN DRAGON BOAT FEDERATION



## PERSONAL INJURY CLAIM FORM



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

**Corporate Services Network**  
GPO Box 4276  
Sydney NSW 2000  
Phone: (02) 8256 1770  
Fax: (02) 8256 1775  
Email: [liberty@csnet.com.au](mailto:liberty@csnet.com.au)



**INSURANCE BROKER FOR THE AUSTRALIAN DRAGON BOAT FEDERATION;**

V-Insurance is a corporate authorised representative of  
Willis Towers Watson Limited. Authorised Representative No. 432898 AFSL: 240600

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

# AUSTRALIAN DRAGON BOAT FEDERATION NATIONAL INSURANCE PROGRAM SUMMARY OF INSURANCE

## 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 (\$20,000 for under 18 and over 80 year olds). The paraplegia and quadriplegia benefit is \$250,000.

## Non Medicare Medical Expenses

Reimburses up to 85% (100% for ambulance expenses) of Non-Medicare medical expenses up to a maximum of \$2,550 (\$5,000 for voluntary workers). Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance – subject to a \$20 excess each and every claim (nil if privately insured or for ambulance expenses). Cover is limited to expenses incurred within twelve (12) months from the date of injury.

## Student Assistance Benefit

Reimburses 100% of costs incurred up to a maximum of \$400 per week for up to fifty two (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 \$400 per week for up to fifty two (52) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy – 14 day excess.

## Parents Inconvenience Allowance

Pays up to \$25 per day up to a maximum of \$1,500, whilst the child is hospitalised to off set costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age.

## Loss of Income

Cover for 85% of your net weekly income or up to a maximum of \$350 per week, whichever is the lesser. The benefit period is fifty two (52) weeks and the excess is 7 days.

## Funeral Benefit

If a death benefit has been paid under capital benefits, an amount of \$10,000 is available for reimbursement of funeral expenses.

## Important Notes

This insurance cover is underwritten by: Liberty Specialty Markets  
ABN 61 086 083 605

1. This summary of cover provides factual information about the Australian Dragon Boat Federation Insurance Program.
2. The policy with full conditions is available by contacting V-Insurance Group.
3. This insurance program commenced on 30 June 2021 and expires on 30 June 2022.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Australian Dragon Boat Federation 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. Australian Dragon Boat Federation is not and does not represent themselves as registered insurance broker by endorsing the products outlined in this claim form.

# HOW TO MAKE A CLAIM

Dear Australian Dragon Boat Federation 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 complete pages 4 & 5 and sign and date the Declaration.
3. Please ensure that both your Club & State Association completes and signs the Declaration on pages 4 & 5.
4. For claims involving Loss of Income:
  - a) You must complete page 6 and have your employer/salary officer complete page 7. If self employed, you must have your accountant complete these details;
  - b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 10.
5. For claims involving Non-Medicare medical expenses:

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).

  - a) Have your Attending Physician complete the "Attending Physician" statement on page 10.
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 completed all sections of the claim form, please have your Club or State Entity complete and sign pages 4 & 5 confirming that your injury occurred during a sanctioned activity.
8. Once you have completed your claim form, please forward to Corporate Services Network. Their contact details are as follows;  
  

Corporate Services Network  
GPO Box 4276  
Sydney NSW 2000  
Phone: (02) 8256 1770  
Fax: (02) 8256 1775  
Email: [liberty@csnet.com.au](mailto:liberty@csnet.com.au)
9. Your reimbursement cheques will be sent to you directly by Corporate Services Network.
10. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.
11. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance Group Team on (02) 8599 8660 or 1300 945 547.



# PERSONAL ACCIDENT CLAIM FORM

## CLAIMANT DETAILS

Name of Club:	Member No (if applicable):	Claimant's Given Name:	Surname:
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth: / /	
Address		State      Postcode	Email:
Phone Number (work): (   )	Home (   )	Mobile	
Please tick the category applicable <input type="checkbox"/> Rower <input type="checkbox"/> Official <input type="checkbox"/> Coach <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 Markets Australia 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 Liberty Specialty Markets Australia and their service providers in order to assess the claim. Liberty Specialty Markets Australia 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 CLUB

Name of Club:	Name of Club Official making this statement:
Position of Official making this statement:	Telephone Number: (   )  Email:

I, the above mentioned Dragon Boat Club Official, confirm that the claimant was a registered and Financial member of the above mentioned club and confirm that the claimant was taking part in an insured activity as defined by the Personal Accident Insurance with Australian Dragon Boat Federation 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.



<p>Do you have any comments in relation to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please detail _____</p> <p>_____</p>
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Dated: / /	Signature of Club Official:
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**DECLARATION BY STATE / TERRITORY ASSOCIATION**

Name of State Association:	Name of State Association Official making this statement:
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Position of State Association Official making this statement:	Telephone Number: ( )
	Email:

Address	State	Postcode
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I, the above mentioned State/Territory Official, confirm that the claimant was a registered and Financial member of the above mentioned State / Territory Dragon Boat Association and was an insured person as identified in the Personal Accident Insurance Liberty Specialty Markets Australia 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.

<p>Do you have any comments in relation to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please detail _____</p> <p>_____</p>
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Dated: / /	Signature of State Association Official:
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Office use only

Policy Number: ATCSI00138

Claim Number: \_\_\_\_\_

## 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"/>

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/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?

If yes, please advise when:  
/ /



**The following information is required for Australian Dragon Boat Federation for research to assist with Risk Management. Answering these questions will not affect your claim.**

During which activity did your injury occur? (please tick)	Training	<input type="checkbox"/>
	Competition	<input type="checkbox"/>
	Other please advise.....	<input type="checkbox"/>
Surface at point of injury? (please tick)	Water/Boat	<input type="checkbox"/>
	Land	<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"/>

# 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: ( )	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: / /      ABN/ACN:
Company Stamp:	

## B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature:	Date: / /
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, 2000

## 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 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

Patient's Full Name:

How long have you known the patient?

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

Patient's Occupation:

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

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

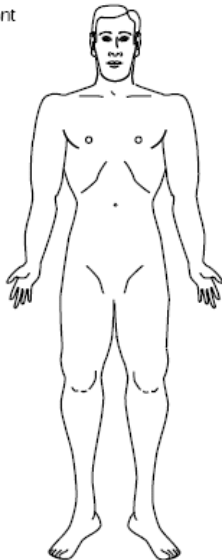
What is the exact nature of the present injury?

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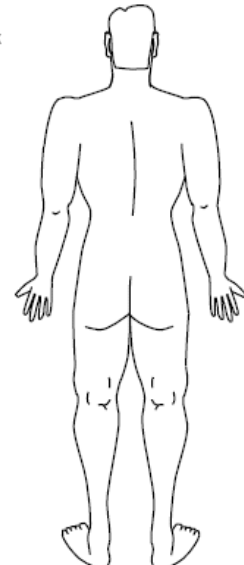


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Front



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 Liberty Specialty Markets Australia 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 Liberty Specialty Markets Australia has instructed its bank to credit the nominated account and that we release Liberty Specialty Markets Australia from any further liability in relation to this payment.
- Liberty Specialty Markets Australia 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 Liberty Specialty Markets Australia collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Liberty Specialty Markets Australia's disclosure of this information, to Liberty Specialty Markets Australia'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 Australian Dragon Boat Federation's insurance brokers, V-Insurance Group.

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

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

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