



## PERSONAL INJURY CLAIM FORM

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

**Paddle Australia**

PO Box 6805

Silverwater NSW 2128

Email: [info@paddle.org.au](mailto:info@paddle.org.au)

Phone: (02) 9763 0670

# PADDLE AUSTRALIA

## SUMMARY OF INSURANCE COVER

### Death & Permanent Disablement

A lump sum benefit is payable in the event of Accidental Death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is \$100,000 when participating in a PA sanctioned event (\$50,000 whilst paddling solo or training) or \$20,000 for members aged 75 to 100 years and members aged between 2 and 18 years old. The maximum paraplegia and quadriplegia benefit is \$175,000.

### Non Medicare Medical Expenses

Reimburses up to 75% of Non-Medicare medical expenses up to a maximum of \$2,500 (\$5,000 for officials and voluntary workers ie all non-participants) with Ambulance Transports Costs reimbursed 100% up to the maximum benefit limit. Claimable expenses are private hospital bed and theatre fees, ambulance, dental, physiotherapy etc, net of any recoveries from private health insurance – subject to a \$50 excess (Nil excess if private health cover held and claiming ambulance transport costs). Cover is limited to expenses incurred within twelve (12) months from the date of injury.

### Student Tutorial Benefit (full time students)

Reimburses up to 100% of parents' costs incurred up to a maximum of \$500 per week for up to twenty six (26) weeks being costs actually incurred for tutoring to assist the full-time student. Excess is 7 days.

### Domestic Home Help Benefit

Reimburses non-wage earners for 100% of costs incurred up to a maximum of \$500 per week for up to twenty six (26) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy. Excess is 7 days.

### Loss of Income

Cover for 85% of your net weekly income or up to a maximum of \$500 per week (whichever is the lesser, maximum of \$250 per week for members aged 75 to 90 years), and \$700 per week for officials and voluntary workers (all non-participants). The benefit period is 104 weeks and the excess is 7 days.

### Broken Bones Benefit

Reimburses up to a maximum of \$3,000 for each insured as per the scale of benefits defined in the policy. There is no benefit paid for persons aged over 75 years.

### Important Notes

This insurance cover is issued by: Arch Insurance  
ABN 27 139 250 605  
Level 4, 68 YorkStreet, Sydney NSW 2000

1. This summary of insurance cover provides factual information about the Paddle 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/paddle](http://www.vinsurancegroup.com/paddle) or by contacting Paddle Australia.
3. This insurance program commenced on 30 June 2020 and expires on 30 June 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Paddle Australia 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. Paddle Australia 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 Paddle Australia insurance program can be obtained by visiting**  
[www.vinsurancegroup.com/paddle](http://www.vinsurancegroup.com/paddle)

# HOW TO MAKE A CLAIM

Dear Paddle Australia 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) Have your Attending Physician complete the page titled "Doctor's Statement" on page 9.
4. For claims involving Non-Medicare medical expenses, complete page 7:

Medical treatment must be certified necessary by an attending physician and incurred within Australia.

  - a) Have your Attending Physician complete the "Attending Physician" statement on pages 8 and 9.
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.

1. Once you have completed your claim form, please forward to Paddle Australia. Their contact details are as follows;

**Paddle Australia**  
PO Box 6805  
Silverwater NSW 2128  
Email: [info@paddle.org.au](mailto:info@paddle.org.au)  
Phone: (02) 9763 0670

2. Paddle Australia will sign off on your claim form and forward it along with your supporting documentation to the insurer.
3. Your reimbursement will be sent to you directly by Corporate Services Network (CSN) .
4. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network (CSN) who can also be contacted by telephone on (02) 8256 1770 or via email [claims@csnet.com.au](mailto:claims@csnet.com.au) should you wish to make enquiries relating to the progress of your claim.
5. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance team on (02) 8599 8660 or 1300 945 547.

# PERSONAL ACCIDENT CLAIM FORM

## CLAIMANT DETAILS

|  |                       |  |          |
|--|-----------------------|--|----------|
| Claimant's Given Name:   |                       | Surname:   |          |
| Club Name:   |                       | Member No  |          |
| 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"/> Paddler <input type="checkbox"/> Official <input type="checkbox"/> Instructor <input type="checkbox"/> Volunteer <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 Corporate Services Network 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 CSN and their service providers in order to assess the claim. CSN complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Declared at \_\_\_\_\_ am/pm In the State/Territory of \_\_\_\_\_

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_  
(or Legal Guardian if under 18 years of age)

## DECLARATION BY CLUB

|  |   |
|--|---|
| Name of Club:  | Club/State Official's Name making this statement: |
| Official Position:   | Telephone Number: ( )<br>Email                    |
| Address  | State Post Code                                   |
| I, the above mentioned Paddle Australia affiliated Club Official, confirm that the claimant was a registered and financial member of Paddle Australia affiliated Club and was an insured person as identified in the Personal Accident Insurance with Arch Insurance 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. |   |
| Signature of Club/State Official   | Date  |

## STATEMENT BY PADDLE AUSTRALIA

I confirm that the above named claimant nominated on this claim form is a paid registered insurance member of the Paddle Australia Personal Accident insurance program.

|                 |                  |
|-----------------|------------------|
| Official's Name | State/Territory: |
| Signature       | Date:            |

## ACCIDENT DETAILS

Describe the accident and how it happened? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe your injury?

When did your accident occur?

Date:     /     /                      Time:                      am/pm

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:

   /     /

What 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

## 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: ...../...../.....   |
| 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

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 3, 3b)

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.

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. 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  
Date Day / Month / Year  
You MUST SIGN here

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? Branch number (if applicable)

30 074 864 609 004

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

4 What is your business address?

LEVEL 10  
33 YORK STREET  
SYDNEY  
State/territory Postcode  
2000

5 Who is your contact person?

ANTHONY ROUHANA  
Business phone number 0282561770

6 If you no longer make payments to this payee, print X in this box.

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.

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.

Sensitive (when completed)



30920716

## 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<br>E.G DENTAL<br>PHYSIOTHERAPY<br>ETC | DATE OF SERVICE | CHARGE | PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE) | AMOUNT CLAIMABLE |
|------------------|---|-----------------|--------|--|------------------|
|                  |   |                 |        |  |                  |
|                  |   |                 |        |  |                  |
|                  |   |                 |        |  |                  |
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|                  |   |                 |        |  |                  |
|                  |   |                 |        |  |                  |
|                  |   |                 |        |  |                  |
|                  |   |                 |        | <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  
Please send completed claim forms and supporting documentation to  
**Paddle Australia**  
PO Box 6805, Silverwater NSW 2128  
Email: [info@paddle.org.au](mailto:info@paddle.org.au)  
For assistance completing this form, please contact V-Insurance Group  
Phone (02) 8599 8660 or 1300 945 547

## 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?

Patient's Occupation:

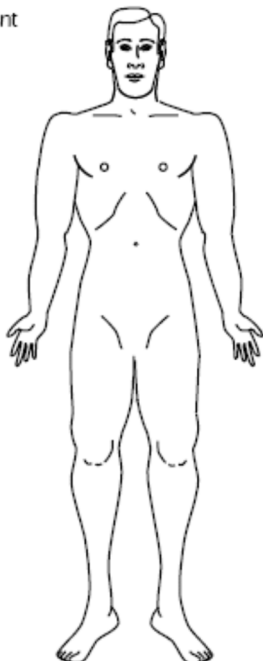
What date and where were you first consulted by the patient in connection with the present injury?     /     /

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

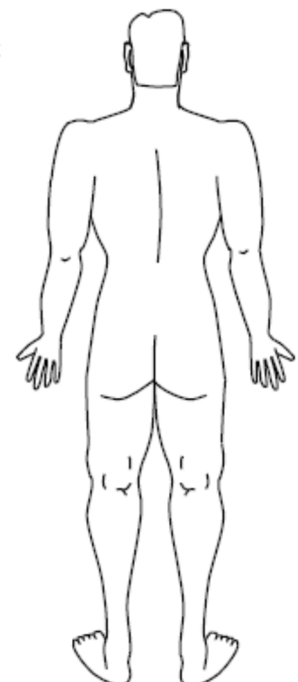
If not, please advise who is .....

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

|                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <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"/> |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

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 Networks 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: \_\_\_\_\_