

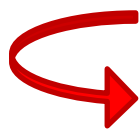


SQUASH AUSTRALIA

SQUASH
AUS



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 SQUASH AUSTRALIA;

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

SQUASH AUSTRALIA

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 (\$25,000 for members aged under 18 and over 75 years old). The paraplegia and quadriplegia benefit is \$100,000.

Non Medicare Medical Expenses

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

Student Tutorial Benefit

Reimburses 100% of costs incurred up to a maximum of \$300 per week for up to fifty two (52) weeks for costs actually incurred for tutoring by a qualified tutor to assist the full time student - 14 day excess.

Domestic Help Benefit – Non Income Earners

Reimburses non-wage earners up to 100% of costs incurred, up to a maximum of \$300 per week for up to fifty two (52) weeks, for reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury – 14 day excess.

Parent's Inconvenience Allowance

Pays up to \$25 per day up to a maximum of \$1,500, whilst the child is hospitalised to offset costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age- 7 day excess

Loss of Income

Cover for 85% of your net weekly income or up to a maximum of \$300 per week, whichever is the lesser. The benefit period is fifty two (52) weeks and the excess is 14 consecutive 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: Canopus Asia Pte Ltd
ABN 167 825 525 77, Canopus Asia Pte Ltd
Suite 25.04, Level 25, 52 Martin Place
SYDNEY NSW 2000

1. This summary of cover provides factual information about the Squash Australia Insurance Program.
2. The policy with full conditions is available at www.vinsurancegroup.com/squashaustralia or by contacting Squash Australia.
3. This insurance program commenced on 30 March 2023 and expires on 30 June 2024.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Squash 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. Squash Australia is not, and does not, represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the Squash Australia insurance program can be obtained by visiting

www.vinsurancegroup.com/squashaustralia

HOW TO MAKE A CLAIM

Dear Squash Australia 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 to 6 and sign and date the Declaration.
3. Please ensure that your Club/Centre sign the Declaration on page 4.
4. 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** 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 complete the page titled "Doctor's Statement page 10.
5. 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 page titled "Doctor's Statement 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 fully completed all sections of the claim form, please have your Club/Centre complete and sign page 4, confirming your injury occurred during a sanctioned activity.
8. Once you have completed your claim form, please forward to Corporate Services Network. They handle all claims for the insurer. Their contact details are:

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone + 61 2 8256 1770
Fax + 61 2 8256 1775
Email claims@csnet.com.au

9. Your reimbursement will be made by Corporate Services Network by direct deposit or cheque.
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 ph: (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 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 Corporate Services Network and their service providers in order to assess the claim. Corporate Services Network comply 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 CLUB/CENTRE

Name of Club/Centre:	Name of Official making this statement:
Position of Official making this statement	Telephone Number: ()
Email:	
I, the above mentioned Squash Australia club/centre, 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 Squash 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.	
Do you have any comments in relation to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please detail _____	

Dated:	Signature of club/centre:

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 game

Travelling to and from activity

Sanctioned fundraising/social event

Please provide the name of the squash club/centre and/or address of where the injury occurred?

Provide the name of any one witness to the injury:

Email 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?

Do you have Private Health Insurance?

If yes, please provide 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?

Yes No

If yes, please advise when? / /

The following information is required for Squash Australia research to assist with Risk Management, answering these questions will not affect your claim

Were you wearing eye protection when your accident occurred? (Please tick)	Yes	<input type="checkbox"/>
	No	<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 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:

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 \$...../ week Gross \$...../ week

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 Worker's Compensation Claim?

Yes

No

A. IF EMPLOYED

Salary officer's name:

Phone Number: ()

Email:

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:

V-INSURANCE GROUP

Authorised Representative No. 432898
 of Willis Towers Watson AFSL: 240600
 Level 25, 123 Pitt Street
 SYDNEY NSW 2000
 Phone (02) 8599 8660 or local call cost only 1300 945 547
 Fax (02) 8599 8661
 Email: sports@vinsurancegroup.com

Office use only
Policy Number: A12883AAA
Claim Number:

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT

IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or 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? / /

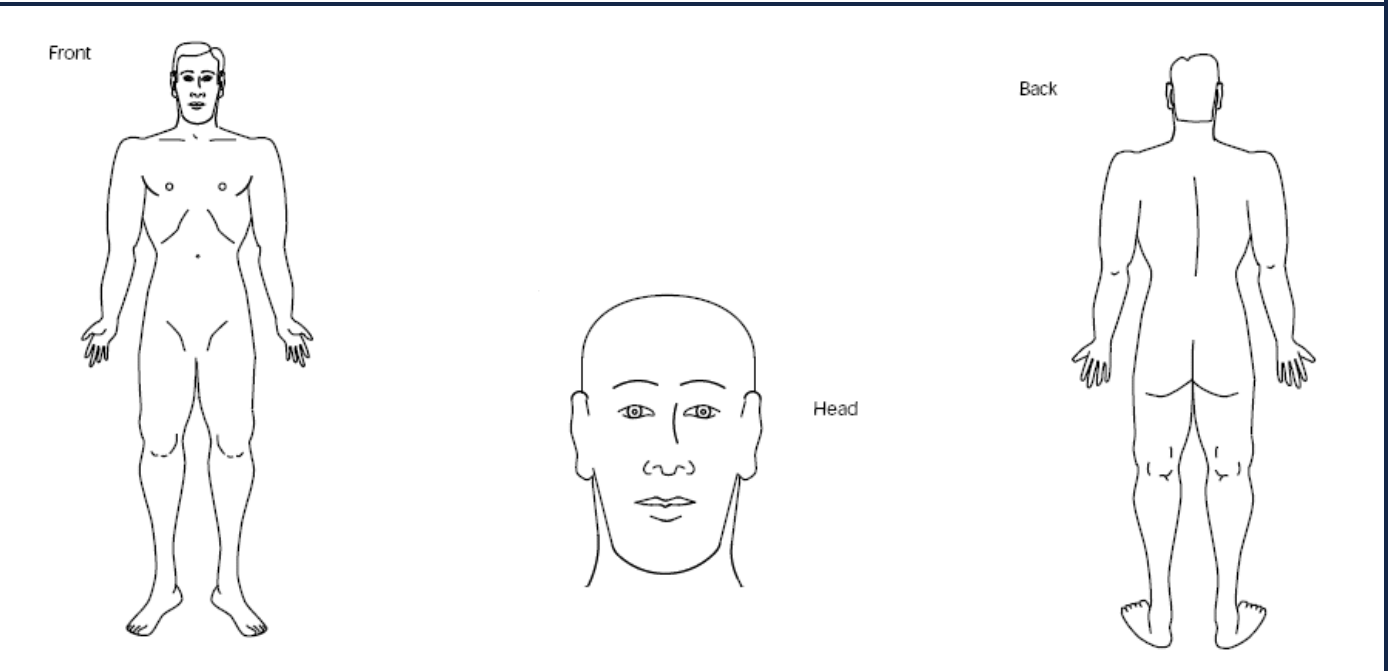
Patient's Occupation:

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)

.....

.....



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 Miss Ms

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"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Account Holder's Full 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 to 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 disclosure of this information, to Corporate Services Network 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 Squash Australia's insurance brokers, V-Insurance Group.

Signature: _____

Date: _____

Print Name: _____