



PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Tenpin Bowling Australia

PO Box 244

Albion QLD 4010

Phone: (07) 3262 4455 Fax: (07) 3262 5544

Email: tenpin.bowling@tenpin.org.au



INSURANCE BROKER FOR TENPIN BOWLING 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

Email: sports@vinsurancegroup.com

TENPIN BOWLING AUSTRALIA SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability up to \$250,000. The scale of benefits is defined in the policy. The death benefit is \$10,000 for persons under 18 years old.

Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses (100% for ambulance costs) up to a maximum of \$5,000. Claimable expenses are private hospital accommodation and theatre fees, ambulance, dental etc, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or claiming ambulance costs only, or \$20 for claimants who do not have private health insurance. Cover is limited to expenses incurred within 12 months from the date of injury.

Loss of Income

Weekly Benefit 85% of earnings, if prevented from working in your Occupation up to a maximum of \$500 per week. 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.

Home Renovation Benefit

If an insured person is entitled to 100% of the Capital Benefit, we will pay up to an additional \$10,000 for costs necessarily incurred to modify the Insured Person's home and/or motor vehicle, or relocating to a suitable home provided that the modifications and/or relocation are prescribed by a legally qualified medical practitioner.

Important Notes

This insurance cover is underwritten by:

DUAL Insurance (Australia)
Level 6, 160 Sussex St, SYDNEY NSW 2000
Ph (02) 9248 6300

1. This summary of cover provides factual information about the Tenpin Bowling Australia insurance program. This information is only a summary of the cover provided. The policy with full conditions is available at www.vinsurancegroup.com/tba or by contacting Tenpin Bowling Australia.
2. This insurance program commences on 31 December 2019 and expires on 31 December 2020.
3. V-Insurance facilitates this insurance program which provides benefits to those registered members of Tenpin Bowling Australia 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.
4. Tenpin Bowling 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 Tenpin Bowling Australia insurance program can be obtained by visiting

www.vinsurancegroup.com/tba

HOW TO MAKE A CLAIM

Dear Tenpin Bowling 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 fully complete pages 4 & 5 and sign and date the Declaration.
3. Please ensure that Tenpin Bowling Australia completes and signs the Declaration on page 4.
4. For claims involving Loss of Income:-
 - a) You must complete page 6 and have your employer/salary officer to 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 complete the "Attending Physician's Report" on pages 9 and 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 is defined as a legally qualified and registered medical practitioner).
 - b) Have your Attending Physician complete the "Attending Physician's Report" on pages 9 and 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 forward to Tenpin Bowling Australia to sign page 4 and confirm your injury occurred during an insured activity. Their contact details are as follows;

Tenpin Bowling Australia
PO Box 244
ALBION QLD 4010
Phone (07) 3262 4455
Fax (07) 3262 5544
Email tenpin.bowling@tenpin.org.au

8. Your claim will be handled by Corporate Services Network. Your reimbursement EFT payment will be issued to you directly by Corporate Services Network.
9. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network will assess and process your claim on behalf of Arch Insurance. Should you wish to make enquiries relating to the progress of your claim, please contact Corporate Services Network directly;

Corporate Services Network
GPO Box 4276
SYDNEY NSW 2001
Phone (02) 8256 1770
Fax (02) 8256 1775
Email claims@csnet.com.au

10. 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 Tenpin Bowling Ltd Registered Centre:	TBA Membership No:	Claimant's Given Name(s): Surname:
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth: / /
Address Postcode	State	Email:
Phone Number (work): ()	Home ()	Mobile
Please tick the category applicable <input type="checkbox"/> Player <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Lane Inspector <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 Arch Insurance and their service providers 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 in order to assess the claim. Corporate Services Network 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 TENPIN BOWLING AUSTRALIA

Name of Tenpin Bowling Australia Official making this statement:

Official Position:	Telephone Number: ()	
	Email:	
Address	State	Postcode

I, the above mentioned Tenpin Bowling Australia Official, confirm that the claimant was a registered and Financial member of Tenpin Bowling Australia and was an insured person was participating in insured activities 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.

Do you have any comments in relation to this claim? Yes No (If yes, please provide details below)

Signature of Tenpin Bowling Australia Official: _____ Dated: / /

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
- Officially organised training
- Social or private competition
- Travelling to and from activity
- Officially organised 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

Please provide a 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?

Please advise when you did (or expect to)

Cease work/normal activities Resume work/normal activities

Cease training Resume training

Cease participating Resume participating

Have you ever had this injury or similar injuries in the past?

If yes, please advise when?
 / /

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
\$ _____

Date commenced employment with company:

/ /

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.

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: ()

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

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.

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 3, 4b)

ato.gov.au

Section A: To be completed by the PAYEE

1 What is your tax file number (TFN)?

Grid for entering TFN: 0000 0000 0000

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

Grid for entering surname

First given name

Grid for entering first given name

Other given names

Grid for entering other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

Grid for entering previous family name

4 What is your date of birth?

Date of birth grid: Day / Month / Year

5 What is your home address in Australia?

Grid for entering street address

Grid for entering street address (continued)

Suburb/town/locality

Grid for entering suburb/town/locality

State/territory Postcode

Grid for entering state/territory and postcode

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?

ABN grid: 30 074 864 609 004

Branch number (if applicable)

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)?

Grid for entering legal name

Grid for entering legal name (continued)

Grid for entering legal name (continued)

DECLARATION by payer: I declare that the information I have given is true and correct.

Signature of payer

Signature and date grid

There are penalties for deliberately making a false or misleading statement.

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

Signature and date grid

There are penalties for deliberately making a false or misleading statement.

4 What is your business address?

Grid for entering business address

Grid for entering business address (continued)

Suburb/town/locality

Grid for entering suburb/town/locality

State/territory Postcode

Grid for entering state/territory and postcode

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.

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.



30920716

Sensitive (when completed)

Authorised Representative No. 432898
 an authorised representative of
 Willis Australia Limited 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

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 a legally qualified and registered medical practitioner.**
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?

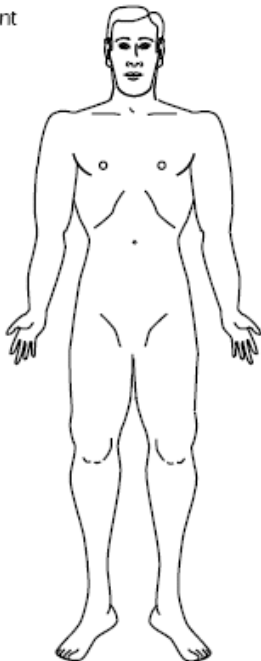
What date and where were you first consulted by the patient in connection with the present injury? / /

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

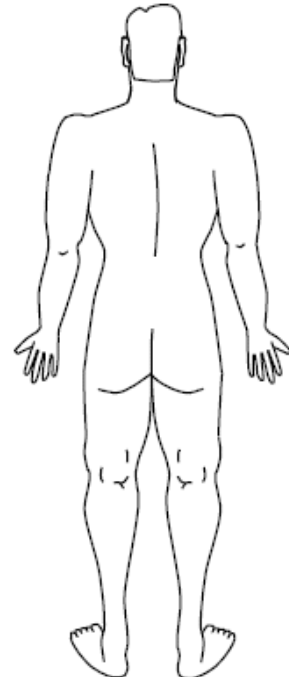
If not, please advise who is _____

What is the exact nature of the present injury? _____

Front



Back



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"/>
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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 Arch Insurance's disclosure of this information, to Arch Insurance'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: _____