V-INSURANCE GROUP

Office use only
Policy Number: BLSAPA001399
Claim Number: _____

TRIATHLON AUSTRALIA

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 TRIATHLON 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

TRIATHLON AUSTRALIA
SUMMARY OF INSURANCE COVER

There are four categories of member under the Personal Accident insurance policy. They are as follows;

a) Professional license holders / elite athletes who are registered financial members of Triathlon Australia.
b) Registered financial members / athletes of Triathlon Australia (amateur athletes) between the ages of 5-90 years of age.
c) Non-competing registered officials of Triathlon Australia including coaches, employees, directors, apprentices, voluntary workers and work experience students.
d) All one day members (covered for death and capital benefits only).

Benefits for each of the above categories are outlined below.

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 $25,000 for category D members and $100,000 for all other category of member ($25,000 if under 18 years old). These benefits are reduced to $50,000 whilst training on a bicycle for category B members.

The following benefits are not available to Category D, One Day Members

Non Medicare Medical Expenses

Reimburses up to 80% of Non-Medicare medical expenses up to a maximum of $5,000 per injury for Category A & C members. Category B members are entitled to 80% of Non-Medicare Medical expenses, up to $3,000 per injury. Claimable expenses are private hospital, 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 $50 for claimants who do not have private health insurance. Cover is limited to expenses incurred within 12 months from the date of injury.

Student Assistance Weekly Benefit (Full time students)

Reimburses up to 80% of costs incurred up to a maximum of $200 per week for up to fifty two (52) weeks for expenses incurred if an Injury covered by your Policy prevents a full time student from going to their usual school / college or other place of learning – 7 day excess.

Home Assistance Benefit

Reimburses up to 80% of costs incurred up to a maximum of $200 per week for up to fifty two (52) weeks being costs actually incurred for home help by a recognised agency – 7 day excess.

Loss of Income

Cover for 100% of your net weekly income for Category A & C up to a maximum of $700 per week, whichever is the lesser. 100% of your net weekly income for Category B members up to a maximum of $400 per week, whichever is the lesser. The benefit period is 52 weeks and the excess is 14 days for Category A & B and 7 days for Category C.

Important Notes

This insurance cover is underwritten by: Blend Insurance Solutions Pty Ltd as agent for Allied World
ABN 47 617 346 353
Level 4,99 Bathurst St, Sydney NSW 2000

1. This summary of cover provides factual information about the Triathlon 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/triathlon or by contacting Triathlon Australia.
3. This insurance program commences 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 Triathlon 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.
5. Triathlon 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 Triathlon Australia insurance program can be obtained by visiting

http://www.vinsurancegroup.com/triathlon

HOW TO MAKE A CLAIM

Dear Triathon 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 pages 9 & 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 Corporate Services Network;

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

7. Reimbursement will be paid to you directly by Corporate Services Network by deposit into your nominated bank account.

8. 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.

9. 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's Given Name: Claimant's Surname:	Member No (If applicable):	Club Name:
Gender (please tick): ❑ Male ❑ Female	Occupation:	Date of Birth / /
Address State Postcode		Email:
Address State Postcode		
Phone Number (work): ( )	Home ( )	Mobile
Please tick the category applicable ❑ Triathlete ❑ Official ❑ Coach ❑ Volunteer ❑ 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 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)

OFFICE USE ONLY

STATEMENT BY TRIATHLON AUSTRALIA STATE ASSOCIATION

I confirm that the above named claimant nominated on this claim form is a paid registered member of the Triathlon Australia Personal Accident Insurance Program. Where the injury occurred during an event, I confirm the event was officially sanctioned by Triathlon Australia.

Name of State/Territory:	Date: / /
Official's Name:	Signature of Association Official:

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 _____ 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: / /

Which Triathlon Australia activity were you participating in at the time of your accident? (please tick)

- ❑ Cycling
- ❑ Swimming
- ❑ Running
- ❑ Other (please advise _____)

Please tick the category applicable (please tick)

- ❑ Professional License Holder
- ❑ Amateur Triathlete, that is a member of TA
- ❑ One Day Member
- ❑ Official
- ❑ Coach
- ❑ Other eg. Volunteer (please advise _____)

Was your activity at the time of the accident? (please tick)

- ❑ Officially organised competition (Event Name _____)
- ❑ Officially organised training
- ❑ Private Training
- ❑ Sanctioned fundraising/social event
- ❑ Travelling to and from activity

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 $ ..... 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 Workers Compensation Claim? ❑ Yes ❑ No

A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature: Company Stamp:	Date: ABN/ACN: / /

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountant's Company Stamp:	Date: / /

Australian Government
Australian Taxation Office

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, 3b)

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.

Yes ☐ No ☐ 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?

Yes ☐ 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. No ☐

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?

Yes ☐ Complete a *Withholding declaration* (NAT 3093). No ☐

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

(b) Do you have a Financial Supplement de

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

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

Signature — You MUST SIGN here

Date Day / Month / Year

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?

30 074 864 609

Branch number (if applicable) 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

Suburb/town/locality SYDNEY

State/territory Postcode 2000

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 02 8256 1770

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 E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
				Total	
				Less Excess	
				TOTAL AMOUNT OF CLAIM	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor: .....

Address: .....

V-INSURANCE GROUP

AR No. 432898 Willis Australia Limited AFSL: 240600
Phone (02) 8599 8660 or local call cost only 1300 945 547
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email claims@csnet.com.au

Office use only
Policy Number: BLSPA001399
Claim Number: _____

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?

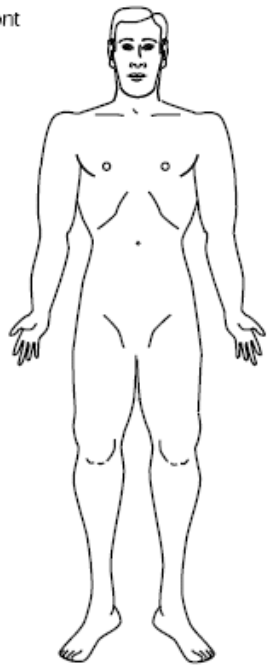
What date and where were you first consulted by the patient in connection with the present injury? / /

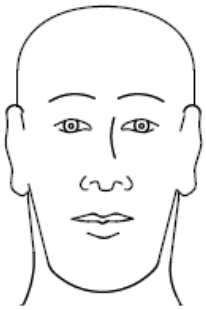
Are you the patient's regular general practitioner? ❑ Yes ❑ No
If not, please advise who is .....

What is the exact nature of the present injury? _____

_____

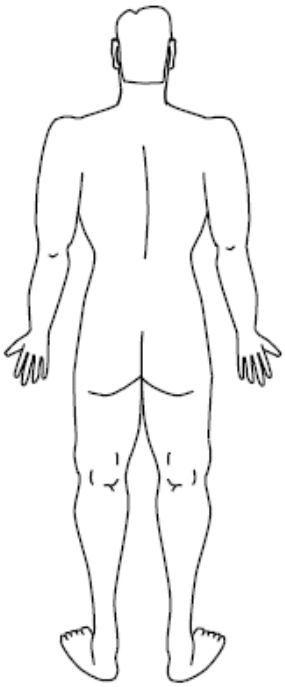
Front





Head

Back



Do you consider the patient's injury to be a new injury? ❑ Yes ❑ No

A recurrence of an old injury? ❑ Yes ❑ No

If yes, please state condition and advise when previous treatment was given.....

.....

Have you referred the patient to any other services or treatment? ❑ Yes ❑ No

Please specify the type and approximate number of treatments required:

❑ Physiotherapy .....

❑ Chiropractic .....

❑ Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated? .....

Are there any further remarks which may assist in assessing this condition? .....

.....

Is there any permanent disability at present? ❑ Yes ❑ No

If yes, please explain giving estimated percentage loss of function .....

.....

Was the patient obliged to cease work? ❑ Yes ❑ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to Cycling? .....

Does the patient have any congenital defects or chronic diseases? ❑ Yes ❑ No

If yes, please give dates, name of treating doctor and describe.....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....

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 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: _____