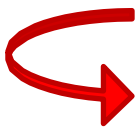




TRIATHLON
AUSTRALIA

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



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

(Category A) Basic Member

Registered financial members / Athletes of Triathlon Australia

(Category B) Standard Member

Registered financial members / Athletes of Triathlon Australia

(Category C) Premium Member

Registered financial members / Athletes of Triathlon Australia

(Category D) Pro Member

Professional License Holders / Elite Athletes who are registered financial members of the Insured.

(Category E) One Day License Member

Registered One Day License members (covered for death and capital benefits only).

(Category F) Non-competing registered officials

Including coaches, employees, directors, apprentices, voluntary workers and work experience students

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 \$50,000 for Category A, \$75,000 for Category B, \$100,000 for Categories C, D & F & \$25,000 for Category E for members over the age of 18 and under the age of 80. The death benefit is \$10,000 for Category A, \$25,000 for Categories B, C, D & F & \$10,000 for Category E for members under the age of 18 and over the age of 80. The death benefit is \$25,000 for Category A, \$56,250 for Category B, \$75,000 for Category C, \$100,000 for Category D & \$12,500 for Category E for members over the age of 18 and under the age of 80 when cycling. The death benefit is \$5,000 for Category A, \$12,500 for Category B, C, & D & \$6,000 for Category E for members under the age of 18 and over the age of 80 when cycling. There is no cover for Category F when cycling.

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

Non Medicare Medical Expenses

Reimburses up to 80% of Non-Medicare medical expenses up to a maximum of \$1,500 per injury for Category A, \$3,000 for Category B and \$5,000 for Categories C, D & F. 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 \$2,000 for Category A, \$3,000 for Category B and \$5,000 for Categories C, D & F 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.

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 with 85% of your net weekly income up to maximum of \$300 for Category A, \$400 for Category B and \$700 for Categories C, D & F, whichever is the lesser. The benefit period is 52 weeks and the excess is 14 days for Category A, B, C, D and 7 days for Category F.

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 2022 and expires on 30 June 2023.
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 Triathlon 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 Network

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): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Birth / /
Category of Member (please tick), please refer to page 2 for membership types A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/>		
Address	State	Postcode
Address		Email:
Address	State	Postcode
Phone Number (work): ()	Home ()	Mobile
Please tick the category applicable <input type="checkbox"/> Triathlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <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 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.

Confirmation of Member Type Verified (please tick): Yes No

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 \$ <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:	



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.

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 debt?
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

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?
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)?

C O R P O R A T E S E R V I C E S

4 What is your business address?
L E V E L 1 0

3 3 Y O R K S T R E E T
Suburb/town/locality
S Y D N E Y
State/territory
Postcode
2 0 0 0

5 Who is your contact person?
A N T H O N Y R O U H A N A
Business phone number
0 2 8 2 5 6 1 7 7 0

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.



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:

Office use only
Policy Number: BLSPA001399
Claim Number: _____

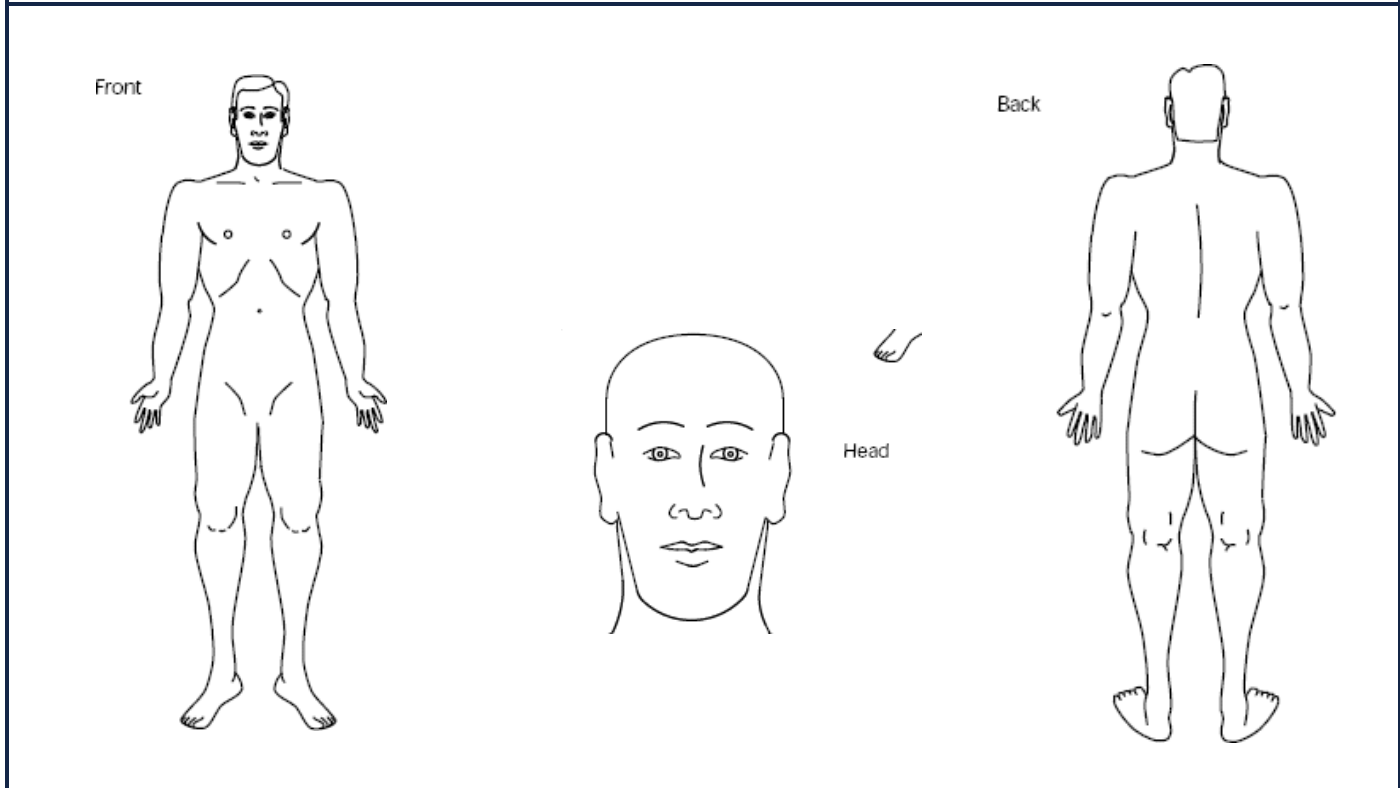
SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, please advise who is	
What is the exact nature of the present injury? _____ _____	



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: _____