

# PERSONAL INJURY CLAIM FORM

FOR INJURIES SUSTAINED BETWEEN 31<sup>ST</sup> AUGUST 2008 AND 31<sup>ST</sup> AUGUST 2009

**NON-MEDICARE MEDICAL AND LOSS OF INCOME CLAIMS ONLY**

For Policy Wordings, Summary of Cover and other information relating to Personal Injury claims, please refer to:

**[www.jltsport.com.au/cricketaustralia](http://www.jltsport.com.au/cricketaustralia)**

**Claims Enquiries:  
1800 640 009**

**Please send your completed claim form and attachments to:**

<b>Echelon Claims Services</b> PO Box 7170, Hutt Street, SA 5000	<b>OR</b>	<b>Fax:</b> <b>(08) 8235 6450</b>
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**General Enquiries:  
1300 655 684**

## HOW TO LODGE A PERSONAL INJURY CLAIM:

- Step 1:** Access a *current* claim form via [www.jltsport.com.au/cricketaustralia](http://www.jltsport.com.au/cricketaustralia) or call Echelon on 1800 640 009
- Step 2:** Complete *all* relevant sections of the claim form.
- Your claim form may be returned if there is important information missing
  - For assistance contact Echelon on 1800 640 009
- Step 3:** Send your claim form to Echelon *as soon as possible* within **180 days** from the date of injury.
- Do not wait for all treatments to be completed before sending your claim form.
  - Treatments may continue even after you have submitted your claim form.
- Step 4:** Echelon will confirm receipt of your claim or make contact with you should they require more information.
- Please contact Echelon directly if you have not received confirmation of your claim within 2 weeks from the date of lodgement.

## IMPORTANT INFORMATION REGARDING PERSONAL INJURY CLAIMS: *Please read the following information carefully*

### Who is Echelon?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of Jardine Lloyd Thompson Pty Ltd. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the National Risk Protection Program.

### We legally can not reimburse you for Medicare-related costs:

The Health Insurance Act (Cth) 1973 does not permit the Insurer or the Trustee to reimburse you for any costs associated with medical treatments registered with Medicare (this includes the Medicare Gap).

### Only Non-Medicare Medical Treatments can be reimbursed (as per the Policy Wording):

- All treatments must be certified as "necessary" by your physician. i.e. Doctor, physiotherapist, etc
- Please refer to JLT Sport's web site ([www.jltsport.com.au/cricketaustralia](http://www.jltsport.com.au/cricketaustralia)) for benefits, excesses and special conditions/exclusions

### Attach Original Receipts:

- Send original receipts with your claim form (unless retained by your private health fund).

### If you have Private Health Cover:

- Claim on your private health fund first and attach a copy of their rebate advice to this form.

### Privacy of your personal details:

- We collect, store and use your personal details in-line with the Privacy Act (Cth) 1988. For a copy of our Privacy Statement please contact JLT Sport on 1300 130 373 or view it online [www.jltsport.com.au](http://www.jltsport.com.au)

### Examples of items covered by Medicare. *We can not reimburse you for these costs.*

- Doctor
- Surgeon
- Surgeon's Assistant
- Anaesthetist
- X-rays
- MRI Scans\*
- Public Hospitals

### Examples of Non-Medicare items. *Claimable as per the Policy Wording.*

- Ambulance
- Physiotherapist
- Dental
- Private Hospital Accommodation
- Chiropractor
- MRI Scans\*

PLEASE NOTE:

*\* MRI scans are generally claimable through Medicare, however please check with your referrer and/or provider to confirm if this is the case prior to lodging your claim.*

## CLAIM FORM CHECKLIST: *Please use the checklist below to ensure ALL sections are completed as required.*

SECTION A:	SECTION B:	SECTION C:*	SECTION D:
<input type="checkbox"/> Claimant's details <input type="checkbox"/> Injury details <input type="checkbox"/> Injury research <input type="checkbox"/> Signed by Claimant	<input type="checkbox"/> Club declaration <input type="checkbox"/> Signed by authorised club representative	<input type="checkbox"/> Confirmation of Loss of Income Cover <input type="checkbox"/> Employment Details <input type="checkbox"/> Signed by Employer	<input type="checkbox"/> Injury details <input type="checkbox"/> Signed by your physician

\* Section C must be completed only when claiming for Loss of Income.

# CLAIM FORM SECTION A:

**THIS SECTION MUST BE COMPLETED IN FULL BY THE CLAIMANT OR A LEGAL GUARDIAN IF THE CLAIMANT IS UNDER 18 YEARS OF AGE.**

*PLEASE PRINT - If there is insufficient space to answer a question, please attach additional sheets.*

1 _____	2 _____	3 <u>Male / Female</u>	4 _____/_____/_____
Claimant's Surname	Claimant's First Name	Gender	Date of Birth (DD/MM/YYYY)
5 _____			6 ( )
Claimant's Personal Mailing Address			Contact Phone Number
7 _____		8 ( )	9 _____/_____/_____
Claimant's Occupation (if applicable)		Work Phone Number	Date of Injury (DD/MM/YYYY)
			10 _____:_____am/pm
			Approx. Time of Injury (HH:MM)
11 _____		12 _____	
Club Name		Association Name	
13 Describe the injury and how it happened (please use additional pages if required).			
14 Describe any other factors that may have contributed to your injury (leave blank if not applicable).			
15 Where did the injury occur?	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	
16 Weather conditions?	<input type="checkbox"/> Fine	<input type="checkbox"/> Showers	<input type="checkbox"/> Extreme heat <input type="checkbox"/> Extreme cold <input type="checkbox"/> Other _____ <small>Please specify</small>
17 Surface conditions?	<input type="checkbox"/> Wet	<input type="checkbox"/> Dry	<input type="checkbox"/> Muddy <input type="checkbox"/> Hard <input type="checkbox"/> Other _____ <small>Please specify</small>
18 Surface type?	<input type="checkbox"/> Indoor (Area)	<input type="checkbox"/> Grass	<input type="checkbox"/> Concrete (Pitch) <input type="checkbox"/> Synthetic (Pitch) <input type="checkbox"/> Matting (Pitch) <input type="checkbox"/> Other _____ <small>Please specify</small>
19 Circumstances at the time of injury?	<input type="checkbox"/> Playing	<input type="checkbox"/> Training	<input type="checkbox"/> Travelling <input type="checkbox"/> Other _____ <small>Please specify</small>
20 Playing position at time of injury?	<input type="checkbox"/> Batting	<input type="checkbox"/> Bowling	<input type="checkbox"/> Fielding <input type="checkbox"/> W/Keeping <input type="checkbox"/> Umpiring <input type="checkbox"/> Other _____ <small>Please specify</small>
21 How did the injury occur?	<input type="checkbox"/> Trip/Fall	<input type="checkbox"/> Hit by ball	<input type="checkbox"/> Collision <input type="checkbox"/> Overuse <input type="checkbox"/> Other _____ <small>Please specify</small>
22 Please indicate when you intend to resume the following activities. If exact dates are not known, please provide approximates.			
_____/_____/_____ <input type="checkbox"/> N/A	_____/_____/_____	_____/_____/_____	
When will you resume WORK?	When will you resume TRAINING?	When will you resume PLAYING?	
23 Do you have private health cover?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
24 If yes, what is the name of your private health fund? _____			
25 Please indicate the covers offered by your private health fund		<input type="checkbox"/> Dental costs	<input type="checkbox"/> Physiotherapy costs
		<input type="checkbox"/> Ambulance	<input type="checkbox"/> Hospital costs
26 Are you a member of the Ambulance Service?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
27 Please indicate to whom re-imbusement cheques are to be made payable for this claim:			
<input type="checkbox"/> Myself		<input type="checkbox"/> Other	
_____		_____	
Contact Person		Cheque made payable to	
_____		_____	
Address		State	Post code
I, the undersigned, hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other authorised members of the JLT Sport (Cricket Australia National Club Risk Protection Programme) Discretionary Trust Arrangement. I allow this information to be used as part of the Trust's risk management processes and reporting criteria. I authorise any hospital, physician or other person who has attended me or any employer, to furnish JLT Sport or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of all records of employers. I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the forgoing particulars are true and correct in every detail. I agree that if I have made, or shall make in any further declaration in respect to said injury, any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the covers shall be void and all rights to recover there under in respect to past or future injuries shall be forfeited.			
28	_____		_____/_____/_____
Claimant's signature (or Parent/Guardian if under 18 years)			Date

## CLAIM FORM SECTION B: CLUB/ASSOCIATION DECLARATION

THIS SECTION MUST BE COMPLETED IN FULL BY AN AUTHORISED CLUB OR LEAGUE REPRESENTATIVE

I, the undersigned, as authorised representative of _____ hereby declare that	
Name of Club/Association	
_____ sustained the injuries outlined on this claim form on _____	
Name of Claimant <span style="float: right;">Date of Injury</span>	
at _____ whilst <input type="checkbox"/> Playing <input type="checkbox"/> Training for _____	<input type="checkbox"/> Home team <input type="checkbox"/> Away team
Time of Injury <span style="margin-left: 100px;">Select one</span>	Name of Claimant's Club/Team
at _____ against _____	Name of Opposition Club/Team (if applicable)
Name of Ground/Place of Injury <span style="margin-left: 100px;">Name of Opposition Club/Team (if applicable)</span>	
I confirm that our Club/Association has completed all registration requirements for the 2008/09 National Club Risk Protection Programme, including the compulsory online Risk Management Education Program via JLT Sport's Web Site ( <a href="http://www.jltsport.com.au/cricketaustralia">www.jltsport.com.au/cricketaustralia</a> ).	
I confirm that the Claimant <input type="checkbox"/> <u>Has not</u> returned to playing/training.	
<input type="checkbox"/> <u>Returned</u> to playing/training on: _____/_____/_____	
Date Claimant returned	
<b>CLUB/ASSOCIATION DECLARATION. This must be signed by an authorised Club/Association Representative. If blank, your claim may be delayed.</b>	
_____ Authorised Club/Association Representative's name (please print)	_____ Authorised Club/Association Representative's Title/Position
_____ Authorised Club/Association Representative's Signature	_____/_____/_____ Date
_____ Authorised Club/Association Representative's contact email	_____ Authorised Club/Association Representative's contact number

# CLAIM FORM SECTION C: LOSS OF INCOME BENEFITS

THIS SECTION MUST BE COMPLETED ONLY IF YOU ARE CLAIMING LOSS OF INCOME BENEFITS.

**1 – 4 to be completed by the Claimant.**

- 1 Do you wish to claim for Loss of Income Benefits?  YES  NO *If NO, please proceed to Section D*
- 2 Can you claim compensation under Worker’s Compensation or any other policy that includes loss of income benefits?  YES  NO
- 3 Have you ever made any previous claims in respect to a personal accident insurance policy or plan?  YES  NO
- 4 Have you engaged in any other income earning employment since you became injured?  YES  NO

**5 – 18 to be completed by the Employer\*.**

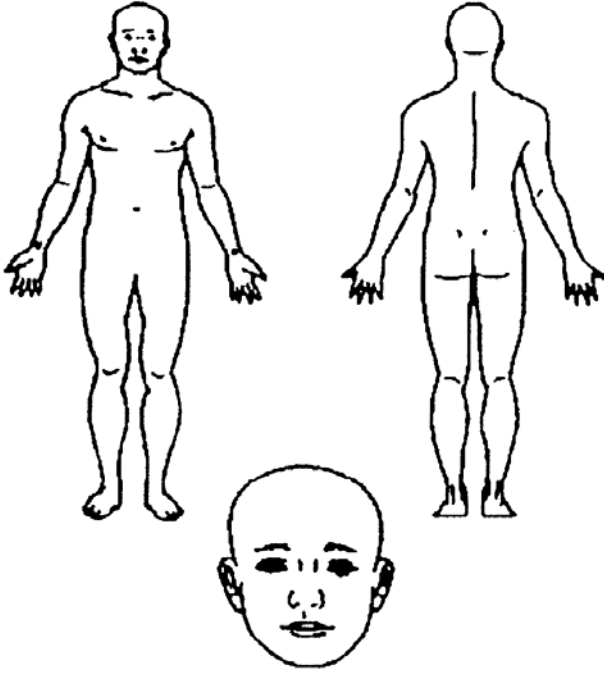
- 5 \_\_\_\_\_ 6 \_\_\_\_\_  
Name of Employer (Business Name) Name of Contact Person
- 7 \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_  
Employer’s address
- 8 ( ) \_\_\_\_\_ 9 ( ) \_\_\_\_\_ 10 \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Employer’s Phone Number Employer’s Facsimile Number Date Employee commenced with the organisation
- 11 \$ \_\_\_\_\_ 12 \$ \_\_\_\_\_  
Employee’s NET weekly salary as at date of injury Employee’s GROSS weekly salary as at date of injury  
*If self employed, please provide average weekly salary based on 12 month period directly prior to injury.*
- 13 What is the Employee’s income definition  Full Time  Part Time  Casual  Self Employed
- 14 \_\_\_\_/\_\_\_\_/\_\_\_\_\_ 15 \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date Employee ceased work due to injury Date expected to resume normal duties
- 16 Has the Employee returned to work?  YES  NO If YES, what date? \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- 17 During the period of incapacity has the employee received a salary?  YES  NO If YES, What for?
- Sick leave Salary received from \_\_\_\_/\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- Annual leave Salary received from \_\_\_\_/\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- Other Salary received from \_\_\_\_/\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- Net of business expenses, personal deductions and income tax; excludes bonuses, commissions, and other allowances; and excluding income derived from playing sport.*

- 18 \_\_\_\_\_  
If Employed - Salary Officer’s Name (please print) Salary Officer’s Phone Number \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_  
If Employed - Salary Officer’s signature
- \_\_\_\_\_ Accountant’s Phone Number \_\_\_\_\_  
If SELF EMPLOYED - Accountant’s name (please print)
- \_\_\_\_\_ Date \_\_\_\_\_  
If SELF EMPLOYED - Accountant’s signature

\*Please note: If you are SELF EMPLOYED, please have your Accountant complete this section.

# CLAIM FORM SECTION D: PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED IN FULL BY YOUR TREATING PHYSICIAN AND WITHOUT EXPENSE TO JLT SPORT.

1 _____ Claimant's Surname	2 _____ Claimant's First Name
3 _____ Claimant's Injury Date	4 _____ Treating Physician's Name (Please Print)
5 Diagnosis / History of Injury	
6 Injury location	7 Injury type
 <p>Please CIRCLE and NAME the area of the body where the injury is located.</p>	<input type="checkbox"/> Bruising <input type="checkbox"/> Concussion <input type="checkbox"/> Cut <input type="checkbox"/> Dental <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Multiple <input type="checkbox"/> Rupture (Internal Organs) <input type="checkbox"/> Sprain (ligament) <input type="checkbox"/> Strain (muscle/tendon)
8 When did the patient first receive medical treatment for the above injury? _____/_____/_____ Date of treatment	
_____ Name of attending physician	
_____ Address	
_____ State	
_____ Post code	
9 Do you consider the Patient's injury to be a NEW injury? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
10 Do you consider the Patient's injury to be a RECURRENCE of a previous injury? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
11 If you consider this injury to be a recurrence from an old injury, please provide details and a description. _____ _____	
13 Does the Patient have any congenital defects or chronic diseases? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
14 If YES, please provide details (including dates, name of treating doctor and description). _____ _____	

Please continue to page 6.

# CLAIM FORM SECTION D: PHYSICIAN'S REPORT (CONTINUED)

15 Have you referred the patient to any other services or treatment?  Yes  NO

16 If YES, please specify the approximate number of treatments required.

Physiotherapy \_\_\_\_\_  
Treatments required

Chiropractics \_\_\_\_\_  
Treatments required

Surgery \_\_\_\_\_  
Treatments required      Please provide surgery details

Other \_\_\_\_\_  
Treatments required      Please provide details

17 Has the patient been able to do any work since the injury occurred?  Yes  NO

18 What date do you advise the patient to return to playing cricket? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date advised to return to football

I, the undersigned, declare that I have examined the Claimant's injury as described on this form. I hereby declare that all information I have provided on this form is true and accurate as at the date of examination.

19 \_\_\_\_\_  
Physician's name (please print)      Physician's Phone Number

\_\_\_\_\_  
Physician's signature      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Incapacity to Work Statement** *Only complete this section if claiming for Loss of Income.*  
 Incapacity to Work Statement must be completed by a Medical Practitioner (i.e. a General Practitioner, Surgeon or a Specialist).  
 It will not be accepted if completed by a Physiotherapist, Chiropractor etc.

I, \_\_\_\_\_ examined \_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_.  
Medical Practitioner's name      Claimant's name      Date of Examination

In my opinion, this person is/has been unfit for work from \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ inclusive.  
First date of incapacity to work      Last date of incapacity to work

Please provide any further comments/remarks in regard to your assessment of this injury/condition.

\_\_\_\_\_  
Medical Practitioner's Name      Medical Practitioner's Phone Number

\_\_\_\_\_  
Medical Practitioner's Address      State      Post Code

\_\_\_\_\_  
Medical Practitioner's Signature      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date