



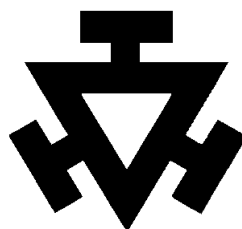
**FOOTBALL
NSW**

PERSONAL INJURY

INSURANCE

CLAIM FORM

(for Futsal members)



H O R S E L L

**INSURANCE BROKERS
CONSULTANTS & MANAGERS**

ABN 65 003 922 487
FSR Licence No 235130

SPORTS PERSONAL ACCIDENT CLAIM FORM

Please find enclosed a claim form.

Before lodging this form with Football NSW Futsal, please ensure all sections are fully completed. Failure to complete all sections of this form may delay settlement of your claim.

Only one claim form (per injury) is required. A claim form should be completed and submitted within 30 days from the date of your injury occurring. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

Please ensure that a General Practitioner, Surgeon, Specialist or Dentist completes the Doctor's Statement. All medical treatment must be certified necessary by a legally qualified medical practitioner.

Please enclose all original receipts for non Medicare medical expenses (if applicable). If you are covered by Private Health Insurance, please also include the statement from your Health insurer.

Once you have completed the claim form, please send it to Football NSW Limited (Futsal Division) to complete the Statement by Football NSW;

Football NSW Ltd
PO Box 6146
BAULKHAM HILLS BC NSW 2153

They will then forward it onto the broker for this scheme, Horsell International Pty Limited.

If you have any further queries please do not hesitate to contact Horsell International Pty Limited, contact details as follows;

Horsell International Pty Limited
Level 12, 189 Kent Street
SYDNEY NSW 2000

Ph: (02) 9247 1700 (24 hours)
or 1300 722 990 – STD Free Outside Sydney Metropolitan Area
Fax: (02) 9247 1733
Email: sports@horsell.com
Website: www.horsell.com



SPORTS PERSONAL ACCIDENT CLAIM FORM

(Every question MUST be fully answered, dashes are not acceptable).

PERSONAL DETAILS

Injured Person's Name _____

Postal Address _____

Phone Numbers Wk () _____ Hm () _____ Mobile _____

Date of Birth _____

Occupation _____ Height _____ Weight _____ Sex: Male/Female

PRIVACY STATEMENT, DECLARATION AGREEMENT & AUTHORISATION BY CLAIMANT

I _____ (Full Name of Claimant) do solemnly and sincerely DECLARE that the information given by me in this claim form is true, complete and correct in every particular and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of any Act of Parliament rendering persons making a false Statement punishable for willful and corrupt perjury, and I AGREE to supply any further information that may be requested of me in connection with my claim, and I AUTHORISE any Doctor, Dentist, Physiotherapist, Company, Firm or person to disclose to QBE Insurance Australia Limited or their representatives any and all information that they may request in connection with my claim.

I consent to the collection, use and disclosure of personal information by QBE Insurance Australia Limited and their Service Providers in order to assess the claim. QBE Insurance Australia Limited complies with the obligations of the Privacy ACT 2001 and the principles laid out in our privacy policy which is readily available upon request

Declared at _____ In the State/Territory of _____

Signature of Claimant (or Legal Guardian) _____ Date _____

STATEMENT BY FOOTBALL NSW LIMITED (FUTSAL DIVISION)

On behalf of Football NSW Limited Futsal department, I confirm that the above named claimant nominated on this Claim Form is a paid Registered Insurance Member of the Football NSW Futsal Personal Accident Insurance Programme.

Football NSW Futsal Official's Name _____ Signature _____

Football NSW Futsal I.D. Number _____ Date _____

ACCIDENT DETAILS

1. Describe the accident and how it happened: _____

2. Describe the injury _____

3. When did the accident occur? Date _____ Time _____ am/pm

4. Where did the accident occur? _____

5. Activity at time of accident

Officially Organised Competition	<input type="checkbox"/>
Official Representative Competition	<input type="checkbox"/>
Officially Organised Practice	<input type="checkbox"/>
Social or Private Competition	<input type="checkbox"/>
Social or Private Practice	<input type="checkbox"/>

Other _____

6. Name and Address of Witness _____

7. Person to whom accident/incident reported _____

8. Time and Date reported _____

9. Brief summary of treatment/action taken
at the time of the accident/incident _____

10. Name and qualifications (if any) of person
who gave treatment _____

11. Was hospitalisation required? _____

Name of hospital and dates confirmed _____

12. Advise when you did (or expect to):

(a)	cease work/normal activities	_____
(b)	cease training	_____
(c)	cease participating	_____
(d)	resume work/normal activities	_____
(e)	resume training	_____
(f)	resume participating	_____

13. Have you ever had this Injury, or similar injury, in the past 5 years? Yes No

If Yes, when ____ / ____ / _____ Treated By _____

14. Have you ever lodged a Personal Accident or Illness claim before? If Yes, please provide details:

Give names, addresses and telephone numbers of all persons who are or have treated you for this condition

Names: _____ Address: _____ Telephone: _____

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 of Health Fund & Member no:

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 eg. Physiotherapy Dental 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 name and address of Referring Doctor:

LOSS OF INCOME (Only complete section if claiming Loss of Income)

1. What is your normal nett (after tax) weekly salary/income? \$ _____

2. Can compensation or benefits be claimed under Worker's Compensation or any other insurance? Yes No
(if Yes, give details) _____

3. Have you engaged in any other income earning employment since you became disabled? Yes No
(if Yes, give details) _____

1. Employer's Statement – If Employed as a Wage Earner (To be completed by your Employer)

I hereby certify that _____ has been unable to attend their usual occupation with the Company as a result of an Injury suffered whilst _____ on ____/____/____

The employee's last day at work was ____/____/____

The employee is expected to/did resume duties on ____/____/____

The employee's salary at the Date of Injury was \$ _____ p/w (nett of tax)

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 ____/____/____

The employee has been employed since ____/____/____

Has the employee lodged or intend lodging a Workers' Compensation Claim Yes No

Name of company _____

Address _____

Signature of supervisor or paymaster _____

Name of supervisor or paymaster (Please Print) _____

Telephone number _____ Date ____/____/____

2. Accountant's Statement – Self Employed Persons Only (To be completed by your Accountant)

I _____ Manager/Accountant/Director/Partner of _____ of
(Name of Firm)

_____ (Address)

confirm that our firm act as Accountants for _____ of
(The claimant)

_____ (Name of Claimant's firm and address)

and His/Her nett earnings (after tax and expenses) for the twelve month period ending ____/____/20____
(date of injury)

amounted to \$ _____

Date ____ / ____ / ____

Signature _____

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 Medical Practitioner, Surgeon, Specialist or Dentist (not Physiotherapist)
3. If 'YES' answered to any of the following, please give details.
4. Dashes or blank spaces are not acceptable

Patient's Full Name: _____

How long have you known the patient? _____

1. (a) What date and where were you first consulted by the patient in connection with the present injury? _____

2. (a) What is the exact nature of the present injury? _____

(b) If X-Ray examination or other tests have been made, state finding and/or quote report. _____

(c) Is the current condition in any way related to their work? _____

3. Is there a previous history of this or similar condition? If Yes, Please give details _____

4. (a) Do you consider the patient's injury to be a new injury? Yes No

(b) A recurrence of an old injury? Yes No

5. Is treatment likely to be prolonged by any complications? _____

6. Do you consider that treatment other than that being received is essential to recovery? _____

7. (a) When was the claimant obliged to cease work? _____

(b) When did or when do you expect the claimant to resume: (i) Some Duties? (ii) Full Duties? (i) _____ (ii) _____

8. If the claimant has been hospitalised, please give name of hospital and dates _____

9. Have you referred the patient to other services or treatment? If Yes, to whom? _____

1. Additional remarks and prognosis. _____

I hereby certify I have personally examined the above-named claimant and that in my opinion the statements made in the Accident Details section of this Claim Form are consistent with the Claimant's Injury.

Name: _____ Telephone Number: _____

Address: _____

Signature: _____ Qualifications _____ Date _____