

# PERSONAL INJURY INSURANCE CLAIM FORM FOR



# SPORTS PERSONAL ACCIDENT CLAIM FORM

Please find enclosed a claim form.

**Please ensure all sections are fully completed prior to submitting your claim. 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 Horsell International Pty Ltd. If you have any further queries please do not hesitate to contact Horsell International Pty Limited.

Horsell International Pty Limited  
PO Box N 661  
Grosvenor Place NSW 1220

Ph: (02) 9247 1700 (24 hours)  
or 1300 722 990 – STD Free Outside Sydney Metropolitan Area  
Fax: (02) 9247 1733  
Email: [sports@horsell.com](mailto:sports@horsell.com)  
Website: [www.horsell.com](http://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 purgery, 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 CENTRE / CLUB

I \_\_\_\_\_ of \_\_\_\_\_  
(Name of Official) (Name of Centre / Club)

hereby certify that \_\_\_\_\_ sustained the injuries resulting in this claim on  
(Name of Player)

...../...../..... at .....am/pm whilst playing / training for .....  
(Skating Discipline)

at .....  
(Place of Game)

Signed: ..... Dated: ...../...../.....

## HORSELL USE ONLY

I confirm that the above named claimant nominated on this Claim Form is a paid Registered Insurance Member of the Skate Australia, Skateboarding Australia and/or Inline Hockey National Personal Accident Insurance Program.

Name of Person at Skate Australia, Skateboarding Australia or Inline Hockey who Confirmed Membership  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

## 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 Event   
Official Representative Competition   
Officially Organised Training or Practice   
Social or Private Competition   
Social or Private Practice   
Travelling To or From Above Events   
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:  
\_\_\_\_\_  
\_\_\_\_\_

## 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:

If you are privately insured, please indicate your level of cover:

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. If your treatment has not been completed, please provide an estimate of ongoing expenses.

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					\$
<b>TOTAL AMOUNT OF CLAIM</b>					\$

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 \_\_\_\_\_