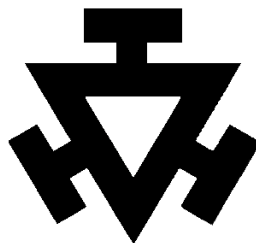




PERSONAL INJURY
INSURANCE
CLAIM FORM



H O R S E L L
INSURANCE BROKERS
CONSULTANTS & MANAGERS

ABN 65 003 922 487
AFS LICENCE NO 235130

SPORTS PERSONAL ACCIDENT CLAIM FORM

Dear Member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. 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 or your guardian fully complete Section A and sign and date the Declaration.
3. Please ensure that you or your guardian fully complete Section B.
4. Please ensure that a Club Official completes and signs the Club Declaration in Section C.
5. For claims involving Loss of Income you must arrange for your employer/salary officer to complete Section D. If self employed, you must have your accountant complete these details;
6. For claims involving medical expenses you must complete Section E.
7. Have your General Practitioner, Specialist or Surgeon complete Section F. (It will **not** be accepted if completed by a Physiotherapist, Chiropractor etc.) Please note that all medical treatment and time away from work must be certified necessary by a Doctor and incurred within Australia.
8. 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 National Health Act does not permit Insurers 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, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

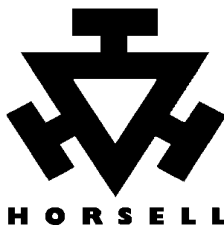
Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

9. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to the Australian Karate Federation who will sign the Statement by Australian Karate Federation in Section C.

Australian Karate Federation
22 Kilcolman Street
THE GAP QLD 4061

10. The Australian Karate Federation will then forward your completed claim form and relating documentation to Horsell International on your behalf. Horsell International Pty Ltd will confirm receipt of your claim form within 5 working days and advise you where to send any ongoing medical receipts and other relating documentation.
11. If you have any further queries relating to your claim, Benefits, Excesses or Special Conditions/Exclusions, please do not hesitate to contact the Horsell International Sports Team on:-

Phone: (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



SECTION A:

**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 _____

Email Address _____

Date of Birth _____

Occupation _____ Height _____ Weight _____ Sex: Male/Female

INFORMATION AUTHORITY AND WARRANTY

I hereby authorise any hospital, physician or other person who has attended me or any employer, to furnish Australis Group Underwriting (AGU), QBE Insurance Australia Ltd (QBE) and Horsell International Pty Ltd (HI) or their representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and information pertaining to employment history and income tax returns. I agree that a photocast copy of this authorisation shall be considered as effective and valid as the original. I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that If I have made, or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress or conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover there under in respect of past or future injuries or sickness shall be forfeited.

PRIVACY CONSENT

I consent to AGU, QBE and HI:-

- a) Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. If we do not collect this information we may not be able to proceed.
- b) Disclosing my personal information to related entities of AGU, QBE and HI, their staff members located outside Australia, the insured, other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Insurance Enquiries & insurance agent or other intermediary, my employer or Insurance Enquiries & Complaints Ltd for the purposes of administering my claim or providing a report.
- c) I understand that a copy of QBE's privacy policy statement, including information about access, may be obtained by visiting www.qbe.com or contacting the Compliance Manager by phone (02) 9375 4656 or by emailing compliance.manager@qbe.com.

SIGNED DATED

(Claimant or Parent or Guardian)

**SECTION B:
ACCIDENT DETAILS**

1. Describe the accident and how it happened: _____

2. Describe the injury _____

3. When did the accident occur? Date _____ Time _____ am/pm
3. Where did the accident occur? _____
4. Type of surface _____
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:

**SECTION C:
CLUB DECLARATION**

I _____ of _____
(Name of Official) (Name of Club)
hereby certify that _____ sustained the injuries resulting in this claim on
(Name of Member)
_____/_____/_____ at _____ am/pm whilst training for _____
(date) (Name of Club)

and I hereby sign this form in acknowledgement of the claim being made.

Signed: _____ Dated ____/____/_____
(Club Official)

STATEMENT BY AUSTRALIAN KARATE FEDERATION

On behalf of the Australian Karate Federation, I confirm that the above named claimant is a paid Registered Insurance Member of the Australian Karate Federation Personal Accident Insurance Program.

Signed _____ Dated ____/____/_____

Print Name _____

SECTION D:
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 _____

**SECTION E:
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. Please indicate if treatment is ongoing.

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:

SECTION F:
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 or Surgeon (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. _____

Name: _____ Telephone Number: _____

Address: _____

Signature: _____ Qualifications _____ Date _____