Sports | Insurance solutions

Football Federation Australia - Claim Form

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. Fullerton Health Corporate Services (FHCS) are authorised by your insurer, Arch Underwriting at Lloyd's (Australia) Pty Ltd, to handle your claim on its behalf and in accordance with its compliance obligations including its obligations under the relevant Privacy legislation.
2. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
3. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability.

PLEASE ENSURE:

- You fully complete <u>every</u> question before your doctor completes his/her statement. Failure to do so will result in delay in handling your claim.
- You must answer ALL questions. If the answer to a question is "No", please state "No"
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.
- **<u>ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT</u>** (e.g. "medical condition" cannot be accepted)

CLAIM NOTIFICATION FORM

NOTE, costs relating to obtaining professional opinion and/or medical reports are not considered part of the claim.

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Claimant to complete:

Certificate/Policy No:			
Team:			
Players Full Name:			
Date of Birth:			
Full Address:			
Suburb:		Postcode:	
Mobile:		Email:	
Telephone Business Hours:			
Telephone Home:			

Claim details

Section 1: Please complete if the Player has suffered an Accident/incident which may give rise to a claim

Section 2: Please complete if the Player is suffering/ has suffered from an injury incurring overseas medical expenses whilst participating in their code of sport which may give rise to a claim

Sections 3 & 4: Please complete for all claims.

NB: If there is not sufficient space, please attach answers on a separate sheet.

Section 1 – Details of Bodily Injury

Treating Doctor to complete

1. The date and time of the Accident/incident:	Date:	Time:
2. What date did the Player first suffer Total Disablement? i.e. What date did the player first become unfit to participate /train in their field of sport?	Date:	Time:
3. Where did the Accident/incident occur?	Location:	
4. Did the Accident/incident occur? Whilst the player was: (please tick the applicable box)		Playing in a competitive match
		Practicing or training
		Involved in other activities
5. Full Details of how the Accident/incident occurred:		
6. Please provide a diagnosis of the injury sustained:		

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7. Please provide a prognosis of the injury sustained:

8. When do you expect the player to be fit for selection?	Date:

9. Has the Player ever suffered injury to, or had treatment for, or had any abnormality to, the injured body part? If so please provide full details:
10. Has the player attended an Emergency Department for this Injury? If yes, please provide details and attach corresponding medical reports.

NB: A Player is fit for selection on the date that he/she is physically able to be selected to play for his/her Club regardless of whether he/she is selected or whether there is a match due.

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TREATMENT PLAN

Please indicate which of the following you have already used or those which you are intending to consider in respect of the injury detailed in Section 1 or the illness detailed in Section 2.If you answer yes to any of the sections below please confirm when you used the treatment or indicate when you intend to consider using the treatment. All dates, periods etc. should relate back to the date of injury or manifestation of the illness. Please also supply all reports and invoices to support these treatments.

		Yes	No	Detail
a)	*Rest*			
b)	*Basic physiotherapy / rehabilitation*			
c)	*MRI Scan*			
d)	*CT Scan*			
e)	*X-ray*			
f)	*Ultra Sound Scan*			
g)	*Consultant Appointment*			
h)	*Exploratory surgery*			
i)	*Restorative surgery*			

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Please Note:

If you are considering h) or i) above please ensure that you provide insurers with full details in writing of any proposed surgical treatment prior to surgery taking place. This information must include full details about:

i) the proposed procedure,

ii) the proposed surgeon,

iii) where the surgery is scheduled to take place,

iv) the total estimated costs

In the event that the Player requires treatment outside Australia please provide full details of:

i) the Player's injury,

ii) intended treatment details,

iii) approximate expected duration of time that will be spent abroad,

iv) the total estimated costs, must be submitted in writing to insurers for approval prior to departure from Australia

Failure to obtain Insurers approval in accordance with the above requirements may invalidate the claim.

Supporting Medical Documentation Required to assess your claim:

Please provide all investigation results and reports relating to the injury you are claiming for.

This includes but is not limited to:

- Medical Certificates confirming dates the player is unable to participate in their field of sport
- MRI Scans
- CT Scans
- X-Rays
- Ultrasound Scans
- Physiotherapy Case Notes/Reports
- General Practitioner case notes/reports
- Specialist Referral reports
- Post operation notes/reports

Please note if you have had a history with the injury or injured body part you are claiming for we may request further information including but not limited to pre-contract medicals, medical information/correspondence held by the players club and previous clubs and electronic copies of past scans (i.e MRI, CT, US scans)

Supporting Documentation required to calculate your Claim amount payable:

- A **signed** copy of the Player's current contract

Section 2 – Overseas Medical Expenses

Claimant to complete if relevant

1. The date and time of the Accident/incident:	**Date:**	**Time:**
2. Type of Injury?		
3. Please provide full details of the accident:		
4. Date of first medical consultation?		
5. Name of Doctor and Hospital?		
6. Details of other treatment by Doctors/Hospital		
7. Dates in Hospital?	**Admitted:**	**Discharged:**
8. Have you ever suffered from the same or a similar condition in the past?		
If YES, please provide full details, including dates.		
9. Are you a member of a Private Health Insurance Fund? e.g Medibank?		
If YES please name the fund. ***N.B If you are a member of a Private Health Fund you must claim from that fund before submitting this claim***		

The following items must be included with this claim:

1. Original Doctor's/Hospital accounts and receipts together with statements from Medicare and Private Health funds
2. Original Doctor's Certificate

Failure to provide these items may result in delays in processing your claim.

Section 3 - DECLARATION

I confirm that the information given on this form and information provided by myself on pages attached to this form is, to the best of my knowledge and belief, true in every respect and that no details relevant to the case have been omitted.

Team Doctor name (please print)	
Team Doctor signature	
Date:	

Payee's Bank details	
When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:	
Bank:	
Account Name(s):	
BSB Number:	
Account Number:	

MEDICAL AUTHORITY AND DECLARATION – CLAIMANT TO COMPLETE

I understand that by investigating my claim or by accepting proof of my claim, FHCS has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to FHCS using and disclosing my personal information pursuant to FHCS's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS such personal information (including health information) as FHCS in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to FHCS in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, FHCS may not be able to process or assess my claim.

Your signature	
Name (printed)	
Date	

PRIVACY STATEMENT

FHCS is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). FHCS will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

FHCS will take all reasonable steps to ensure that personal information held by FHCS is secure from any mis-use, interference, loss, unauthorised access, modification or disclosure.

FHCS has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.fullertonhealthcs.com.au and send to privacy@fullertonhealthcs.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

Arthur J Gallagher Claims Personnel contact

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Postal Address

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