



**Personal Accident Claim Form**  
**Australian Veteran Cycling Council Inc.**  
31 December 2014 to 31 December 2015



**Arthur J. Gallagher**  
BUSINESS WITHOUT BARRIERS™

Please complete Parts 1–8 of this claim form (pages 2 - 5), plus the injury data collection questions on pages 7 - 10

1. Ask Your doctor to complete the 'Medical Statement' (pages 11 - 13)
2. If you are covered for loss of earnings and you wish to make a claim in that regard:
  - a. Ask Your employer to complete Part 9 (page 6). If You are self-employed please have Your accountant complete these details
  - b. Forward a medical certificate every two weeks if Your disability is continuing
3. An authorised official of Your club must complete Part 10 (page 6)
4. Please refer to 'Notes for claimants' on page 14
5. To maximise claims handling efficiency send your completed claim form to Arthur J. Gallagher | Brisbane, GPO Box 1113, 4001.

## 1: The State Body

State body: \_\_\_\_\_

Association name: \_\_\_\_\_

Club: \_\_\_\_\_

Age group: \_\_\_\_\_

## 2: The Member

Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: (Work): \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex:  Male  Female

Licence Number: \_\_\_\_\_

### To be completed by rider

*I hereby authorise Arthur J. Gallagher and any hospital, physician or other person who has attended to me, or any employer, to furnish QBE Insurance (Australia) Limited or Lloyds of London, depending on who is the insurer under the Policy, or its representatives, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorization 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 fraudulent statements or conceal, or suppress, or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sickness shall be forfeited.*

<b>Signature</b>		<b>Date</b>	
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### 3: Details of the Member's Injury

What is the nature of **Your** injury? \_\_\_\_\_

What body part/s has been injured? \_\_\_\_\_

Is it a recurrence of a previous injury?  Y  N

How did it happen? \_\_\_\_\_

\_\_\_\_\_

Where were **You** when it happened? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 3: Details of the Member's Injury (continued)

Type of location:  Velodrome  Training - Road  Event Course - Road  Other

If 'Other' please describe: \_\_\_\_\_

When did the injury occur? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

What were **You** doing?  Racing  Warm up  Training  Other sport

If 'Other' please describe: \_\_\_\_\_

What was the event?  Competition  Regular Sanctioned training  Training camp  Other

If 'Other' please describe: \_\_\_\_\_

### 4: Details of the Member's treatment

Name and address of each hospital **You** attended: \_\_\_\_\_

\_\_\_\_\_

Date of: Admission: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Discharge: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name, address and phone numbers of all attending doctors: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name, address and phone number of **Your** usual doctor \_\_\_\_\_

\_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### 5: Details of the Member's previous Disabilities, injuries or claims

Were **You** suffering any previous medical condition? Y N

If 'Yes', give details of the condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? Y N

If 'Yes', what was the date of injury \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Who was the insurer? \_\_\_\_\_

How much were **You** paid? \_\_\_\_\_

What was the injury? \_\_\_\_\_

Name and address of the doctor: \_\_\_\_\_  
\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### 6: Details of the Member's insurance

Are **You** a member of a health fund? Y N

If 'Yes', what type of membership do **You** have? Hospital cover only Ancillary cover only Hospital plus ancillary benefits

Name of health fund: \_\_\_\_\_

Membership number: \_\_\_\_\_

Any other details regarding private health cover: \_\_\_\_\_  
\_\_\_\_\_

Do **You** have any other insurance to cover this disability or Injury? Y N

If 'Yes', please show name and address of insurer \_\_\_\_\_  
\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### 7: Illegal Substances and intoxicating liquor

Were **You** under the influence of any Illegal Substances or intoxicating liquor when the disability or injury took place Y N

If 'Yes', please give details: \_\_\_\_\_  
\_\_\_\_\_

Have **You** taken any performance enhancing drugs? Y N

### 8: The Member's declaration

By signing this claim form I declare that:

1. All the information that I have given in this form is correct
2. I authorise any doctor, hospital or other person who has treated me to provide Arthur J. Gallagher or its representative with any medical records for any illness or injury I have suffered.
3. I authorise my employer to provide Arthur J. Gallagher or its representative with details of my salary and working hours.
4. I agree that a photocopy of this authorisation will be accepted as valid.
5. I agree to allow the insurer to ask or tell other insurers or insurance reference bureaux about this or any other claim I have made.

Must be completed by the injured **Member**

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### 9: The Member's employment details (Must be completed by pay clerk/paymaster)

Employer's name: \_\_\_\_\_

Employer's address: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone number: \_\_\_\_\_

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury. (Excluding bonuses, commissions, overtime or any other allowances) \$ \_\_\_\_\_

Date **You** expect **Your** employee to resume work \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date **You** expect **Your** employee to resume normal duties (fully fit) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What is **Your** employee's gross annual salary? \$ \_\_\_\_\_

What date did he or she commence employment? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury (net of business expenses, but before income tax and personal deductions e.g. Tax Return)

What is the name of **Your** pay clerk? \_\_\_\_\_

What is **Your** pay clerk's phone number? \_\_\_\_\_

Signature of pay clerk / paymaster: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### 10: Club Veteran Cycling Council declaration

Must be completed by the Club Secretary or Treasurer

I \_\_\_\_\_ Secretary or Treasurer

of \_\_\_\_\_ Name of club and association

Confirm that \_\_\_\_\_ Member's name

Sustained the injuries resulting in this claim on:

\_\_\_\_\_ Date at \_\_\_\_\_ Time

While training or racing for \_\_\_\_\_ Team

During the \_\_\_\_\_ AVCC Sanctioned Event

or while taking part in \_\_\_\_\_ Activity

at \_\_\_\_\_ Place of activity

The first consultation with a doctor for this injury was on:

\_\_\_\_\_ Date

at \_\_\_\_\_ Address of doctor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Club mailing address: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### 11: State Veteran Cycling Council declaration

Must be completed by the State Secretary or Treasurer

I \_\_\_\_\_ *Secretary or Treasurer*  
of \_\_\_\_\_ *Name of State and association*  
Confirm that \_\_\_\_\_ *Member's name*

Sustained the injuries resulting in this claim on:

\_\_\_\_\_ *Date* at \_\_\_\_\_ *Time*

While participating in the advised activity described in part 10.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

AVCC mailing address: \_\_\_\_\_  
\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

#### State Association/AJG Office Use Only

Player Registration Number: \_\_\_\_\_

Signed: \_\_\_\_\_

Position: \_\_\_\_\_

State Association Stamp Where Applicable: \_\_\_\_\_

### Injury data collection

Arthur J. Gallagher is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. Arthur J. Gallagher, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was **Your** role at the time of Your injury? Participant Coach Umpire/Referee Other Official  
Voluntary Worker Spectator Other

If 'Other' please provide details:

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How far into the activity were **You** at the time of the injury?  
*(Note: Your answer relates to the time into the activity, rather than the period/stage of the game)*

Warm up During Race  
Training Cool Down

On what surface were **You** participating? Grass Synthetic Surface Wooden Floor  
Gravel Concrete/Bitumen Other

If 'Other' please provide details:

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What was the condition of the surface? Normal Hard Wet Muddy Other

If 'Other' please provide details:

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What were the weather conditions as the time of injury? Fine Light Rain Heavy Rain Other

If 'Other' please provide details:

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What were the temperature conditions at the time of injury? Very Hot Hot Hot & Humid Mild  
Cold Very Cold Windy Other

If Windy please provide details of conditions – knots, direction etc

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If 'Other' please provide details:

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How was the onset of injury? Sudden Gradual Started With Pre-Existing Injury

If a collision injury, what did **You** collide with? Ground Equipment Other rider Other Structure

If 'Other' please provide details:

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Was protective equipment,



including Australian Standard Approved Helmet, tape or support being worn on the injury site?

Yes No

If yes, please provide details:

Taping Protective Equipment Other Support

If 'Protective equipment', please provide details:

If 'Other support', please provide details:

How did the injury severity affect Your Participation?

Unable to Continue Continued to participate After Treatment  
Continued to participate Without Treatment

What was the immediate treatment? (more than one box may be ticked)

Rest Ice Compression Elevation  
Stretching Mobilisation Taping Bandaging  
Sling Splint Other Unknown

If 'Other' please provide details:

Was a first aid officer present at the event?

Yes No Unknown

If Your injury required referral, to whom were **You** referred?

Hospital Doctor Physiotherapist Dentist Other

If 'Other' please provide details:

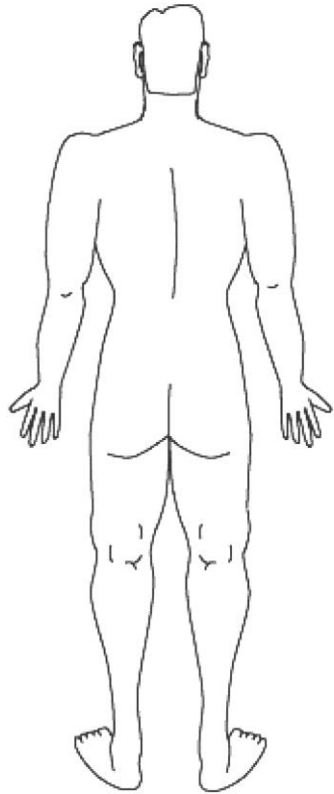
If immediate off site treatment was necessary, what mode of transport was used?

Ambulance Private Vehicle Event Medical Services Other

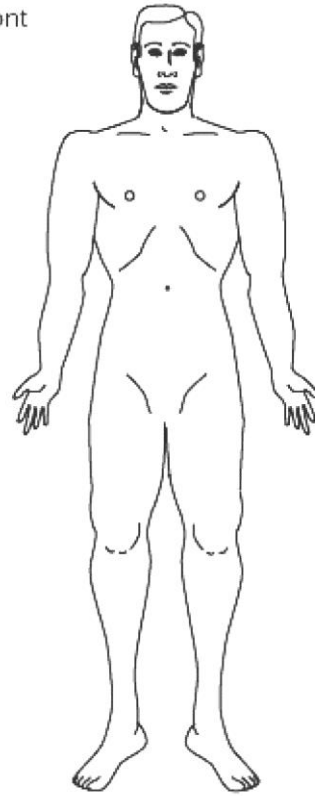
If 'Other' please provide details:

Please indicate the site of your injury on the appropriate diagram below:

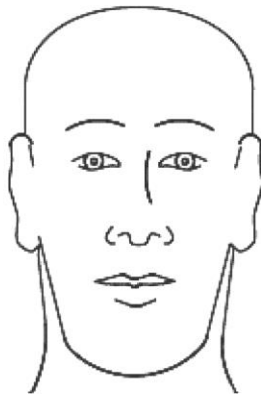
Back



Front



Head



## Medical statement

This form must be completed by the registered medical doctor treating the injury

### The AVCC Association and Club

Association name: \_\_\_\_\_

Club name: \_\_\_\_\_

Type of sport: \_\_\_\_\_

### The Member

Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

### The injury

Complete Diagnosis \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### History

When did the present disability or injury occur? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date the player ceased work: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is there a history of the same or similar condition? \_\_\_\_\_

Is this a recurrence?  Y  N

### Present condition

Subjective symptoms: \_\_\_\_\_

Objective finding (give reports of any x-rays, ECGs or other tests) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the player  Walking  Bed confined  House confined  Hospital confined

Date of admission: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Treatment of present condition

Date of first consultation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of latest consultation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Frequency of consultations: \_\_\_\_\_

Date of last hospitalisation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of hospital: \_\_\_\_\_

Nature of surgical procedure: \_\_\_\_\_

\_\_\_\_\_  Contemplated  Performed

**Progress**

If performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Has condition improved?  Y  N

If 'No', please explain:

**Degree of disability**

Has the patient been able to do any work?

If 'No', from what date

Regular work: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Light duties: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

When will the patient be able to resume for

Regular work: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Light duties: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Other treatment**

If the patient was seen in consultation. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

by another doctor, please give the date,  
name and address of that doctor

\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

If the patient is no longer under your care, what date were your services terminated? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Other conditions**

Describe any other disease or infirmity affecting the patient's present condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please complete the appropriate section if the disability or injury is due to:*

**Cardiac-circulatory**

Blood pressure: \_\_\_\_\_

Circulatory disorder – please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Visual**

Is the patient totally or industrially blind?  Y  N

If 'No', what was the vision at  
last observation:

With glasses:  Distant  Near Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Without glasses:  Distant  Near Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What is the extent of any gross visual field defect? \_\_\_\_\_

Could vision be improved by treatment, surgery or lenses? Y N

What are the rehabilitation prospects? \_\_\_\_\_

\_\_\_\_\_

**Orthopedic**

Please report findings of specialist if referred? \_\_\_\_\_

\_\_\_\_\_

**Neurological**

Please report findings of specialist if referred? \_\_\_\_\_

\_\_\_\_\_

**Prognosis**

\_\_\_\_\_

**Remarks**

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Degree: \_\_\_\_\_

Name of Doctor  
(please print): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

*Please apply doctors name stamp below*

## Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference.

### Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

### Loss of income claim (if eligible)

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

### Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the Sports Injury Claim Form, Medical Statement, Injury Data Collection questionnaire and any applicable Addendums to Injury Data Collection questionnaires are fully complete**

2. **Please forward your completed Sports Injury Claim Form to your Club Secretary who will on forward to the State Secretary for completion of declaration. It would be appreciated if the State Secretary could forward the claim form to Arthur J. Gallagher within 30 days of injury.**
3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

## Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for Arthur J. Gallagher Insurance Brokers Ltd. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer your complaint to the Insurance Broking Division of the Financial Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

## Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the Arthur J. Gallagher web site at [www.ajg.com.au](http://www.ajg.com.au) or telephone 1800 240 432.

## Claims Handling

Claims are processed at Arthur J. Gallagher Brisbane office State Secretary's, please forward the completed claim form to:

### Brisbane

Level 2, 601 Coronation Drive Toowong Qld 4066

T: 07 3367 5000

F: 07 3367 5100

[brisbane@ajg.com.au](mailto:brisbane@ajg.com.au)