Willis

Willis Australia Limited
ABN: 90 000 321 237
AFS License Number 240600

Office use only
Policy Number:…….SUA/002395
Claim Number:……

AUSTRALIAN BASEBALL FEDERATION

AUSTRALIAN BASEBALL

PERSONAL INJURY CLAIM FORM

INSURANCE BROKER FOR
THE AUSTRALIAN BASEBALL FEDERATION;

Willis Australia Limited
HEAD OFFICE
Level 5, 179 Elizabeth Street, SYDNEY NSW 2000
Phone (02) 9285 4111
or
local call cost only 1300 WILLIS (i.e 1300 945 547)
Fax (02) 9283 5276
Email: sports.au@willis.com
Website: www.willis.com.au

CLAIM FORMS ARE TO BE SENT TO;

Claims Services Australia
PO Box 2717
TAREN POINT NSW 2229
Phone (02) 9541 8423
or
local call cost only 1300 363 413
Fax (02) 9524 9003
Email: sua@claimsservices.com.au

AUSTRALIAN BASEBALL FEDERATION
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $100,000 (other than anyone under 18 years old $20,000 maximum). The paraplegia and quadriplegia benefit is $200,000.

Non Medicare Medical Expenses

Reimburses up to 80% of Non-Medicare medical expenses up to a maximum of $2,250. Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or $20 for claimants who do not have private health insurance. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

Student Assistance Benefit

Reimburses 100% of costs incurred up to a maximum of $400 per week for up to fifty two (52) weeks being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student – 14 day excess.

Home Help Benefit

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of $400 per week for up to fifty two (52) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy – 14 day excess.

Parents Inconvenience Allowance

Pays up to $25 per day of costs to a maximum of $1,500, whilst the child is hospitalised to off set costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age. The maximum benefit period is fifty two (52) weeks and the policy excess is 14 days.

Loss of Income

Cover for 80% of your net weekly income or up to a maximum of $250 per week, whichever is the lesser. The benefit period is fifty two (52) weeks and the excess is 10 days.

Funeral Benefit

If a death benefit has been paid under capital benefits, an amount of $5,000 is available for reimbursement of funeral expenses.

Membership Benefit

Important Notes

This insurance cover is underwritten by:- Sports Underwriting Australia on behalf of Calliden Insurance Limited
ABN 53 119 852 096 PO Box 288, KEW EAST VIC 3102

1. This information is only a summary of the cover provided. The policy with full conditions is available by contacting the Australian Baseball Federation (ABF).

2. This insurance program commences on 31 August 2009 and expires on 31 August 2010.

3. Willis Australia Limited has arranged this insurance program to provide benefits to those registered members of the ABF who, through injury or accident, incur financial loss and who would not have otherwise received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.

4. The ABF is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

Further details on the Australian Baseball Federation insurance program can be obtained by visiting www.willis.com.au/abf

HOW TO MAKE A CLAIM

Dear Australian Baseball Federation (ABF) 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 fully complete pages 4 & 5 and sign and date the Declaration.

3. Please ensure that your Association official completes and signs the Association Declaration on page 4.

4. For claims involving Loss of Income:-

a) You must complete page 6 and have your employer/salary officer to complete page 6. If self employed, you must have your accountant complete these details;

b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 8.

5. For claims involving Non-Medicare medical expenses:-
Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).

a) Have your Attending Physician complete the "Attending Physician" statement on page 8.

6. 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 Australian Health Insurance Act does not permit us 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.

7. Once you have fully completed all sections of the claim form, please have your Association/Club complete and sign page 4 and confirm your injury occurred during a sanctioned activity.

8. Once you have completed your claim form, please forward to Claims Services Australia. They handle all claims for the insurer. Their contact details are as follows;

Claims Services Australia
PO Box 2717
TAREN POINT NSW 2229
Phone (02) 9541 8423
or
local call cost only 1300 363 413
Fax (02) 9524 9003
Email: sua@claimsservices.com.au

9. Your reimbursement cheques will be sent to you directly by Claims Services Australia.

10. Once your claim is registered, you can submit ongoing invoices via Claims Services Australia. Claims Services Australia can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

11. If you have any further queries relating to your claim or the cover, please do not hesitate to call the Willis Sports Team on ph: (02) 9285 4111 or 1300 WILLIS (i.e 1300 945 547).

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Name of Association:	Name of Club:	Member No (if applicable):	Claimants Given Name: Surname:

Name of team/age group/grade:

Gender (please tick): * Male * Female	Occupation:	Date of Birth: / /

Address State Postcode	Email:

Phone Number (work): ( ) Home ( ) Mobile

Please tick the category applicable * Player * Official * Coach * Umpire * Other

If Other, please advise _____

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I_____(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Calliden Group Limited via Sports Underwriting Australia to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Calliden Group Limited via Sports Underwriting Australia and their service providers in order to assess the claim. Calliden Group Limited via Sports Underwriting Australia complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant (or Legal Guardian if under 18 years of age) _____ Date _____

DECLARATION BY ASSOCIATION / CLUB

Name of Association / Club:	Name of Association / Club Official making this statement:
Official Position:	Telephone Number: ( ) Email:

Address State Postcode

I, the above mentioned Australian Baseball Federation Official, confirm that the claimant was a registered and Financial member of this Australian Baseball Federation Association / Club and was an insured person as identified in the Personal Accident Insurance with Calliden Group Limited via Sports Underwriting Australia at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? * Yes * No

If yes, please detail_____

_____

Dated: / /	Signature of Association / Club Official:

Office use only
Policy Number:…….SUA/002395
Claim Number:……..

ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury?

When did your accident occur?
Date: / / Time: am/pm

Was your activity at the time of the accident? (please tick)	Officially organised competition	( )
	Officially organised training	( )
	Social or private competition	( )
	Travelling to and from activity	( )
	Sanctioned fundraising/social event	( )

Please provide the address of where the injury occurred:

State the name of any one witness to the injury:	Address of Witness:
Person to whom accident/incident was reported?	Date and time reported? Date: / / Time: am/pm

Brief summary of treatment/action taken at the time of the accident/incident:

Was hospitalisation required?	If yes, please advise the name of hospital:
If admitted into hospital, how long were you there?	Name of person who gave treatment?
Do you have Private Health Insurance?	If yes, please give fund name:

Advise when you did (or expect to):	Cease work/normal activities _____
	Cease training _____
	Cease participating _____
	Resume work/normal activities _____
	Resume training _____
	Resume participating _____

Have you ever had this injury or similar injuries in the past?	If yes, please advise when: / /

The following information is required for Australian Baseball Federation research to assist with Risk Management. <u>Answering these questions will not affect your claim.</u>		
Where did your injury occur? (please tick)	Indoor	( )
	Outdoor	( )
Surface at point of injury? (please tick)	Grass	( )
	Astroturf / Synthetic Grass	( )
	Other, please advise……	( )
Weather conditions? (please tick)	Fine	( )
	Rain	( )
	Showers	( )
	Extreme Heat	( )
	Extreme Cold	( )
Surface Conditions? (please tick)	Wet	( )
	Dry	( )
	Other, please advise……	( )

LOSS OF INCOME
(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(Please tick the box)	YES	NO
1. Can compensation be claimed under Workers Compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER / SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer:	State Postcode
Date ceased work due to injury: / /	Date expected to resume normal duties: / /
Employee weekly salary as at date of injury: Net $..... Gross $..... If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

* Self Employed * Full Time * Part Time * Casual

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	……/……/……

Has the employee returned to work? * Yes * No

Has the employee lodged or intending to lodge a Workers Compensation Claim? * Yes * No

A. IF EMPLOYED

Salary officers name:	Phone Number: ( )
Salary officers signature: Company Stamp:	Date: ABN/ACN: / /

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountants Company Stamp:	Date: / /

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.

NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY 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 the name and address of referring doctor:

Name of Doctor:.....

Address: .....

Office use only Claim Number:……

Willis Australia Limited
ABN 90 000 321 237 AFS 240600

Level 5, 179 Elizabeth Street, SYDNEY NSW 2000
Phone (02) 9285 4111
or
local call cost only 1300 WILLIS (i.e 1300 945 547)
Fax (02) 9283 5276
Email: sports.au@willis.com
Website: www.willis.com.au

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

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 or Physiotherapist.**
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

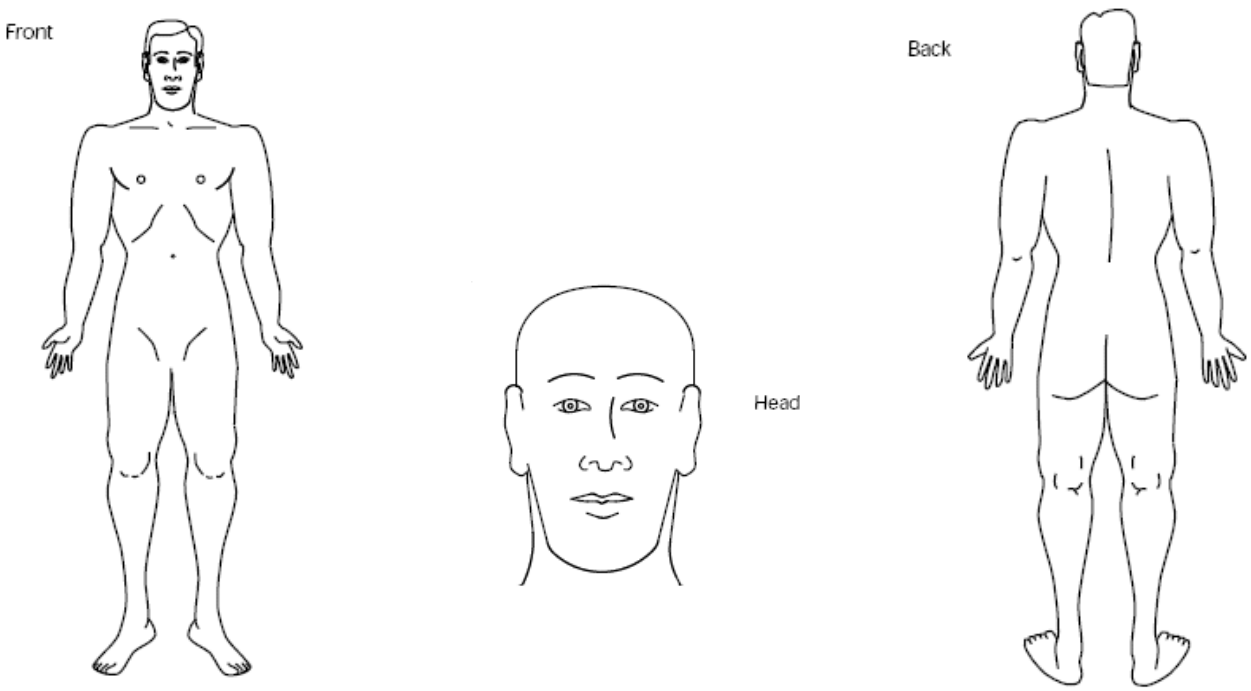
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Full Name:	How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?
/ /

Are you the patient's regular general practitioner? * Yes * No
If not, please advise who is .....

What is the exact nature of the present injury?



Do you consider the patients injury to be a new injury? * Yes * No

A recurrence of an old injury? * Yes * No

If yes, please state condition and advise when previous treatment was given.....

.....

Have you referred the patient to any other services or treatment? * Yes * No

Please specify the type and approximate number of treatments required:

* Physiotherapy .....
* Chiropractic .....
* Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated?.....

Are there any further remarks which may assist in assessing this condition? .....

.....

Is there any permanent disability at present? * Yes * No

If yes, please explain giving estimated percentage loss of function.....

.....

Was the patient obliged to cease work? * Yes * No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to baseball? .....

Does the patient have any congenital defects or chronic diseases? * Yes * No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name:..... Telephone Number: ( ) .....

Fax: ( )..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date:.....

METHOD OF PAYMENT

Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account

Please indicate your preferred method of payment (please tick) * Cheque * EFT

If you would like your payment made by EFT, please complete the details below.

NAME OF CLAIMANT

Title: * Mr. * Mrs * Miss

Name: _____

BANK ACCOUNT DETAILS

BSB number (all 6 digits are required here) Account Number

* * * * * * * * * * * * * * *

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch: _____

DECLARATION

I hereby authorise Claims Services Australia Pty Ltd (CSA) as agents of Calliden Limited (Calliden) to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when CSA has instructed its bank to credit the nominated account and that we release CSA from any further liability in relation to this payment.
- CSA is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to CSA collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to CSA's disclosure of this information, to CSA's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988.* I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.

Signature:_____ Date: _____

Print Name: _____