MARSH

MARSH SPORT PERSONAL INJURY CLAIM FORM

Bushwalking Australia Risk Protection Programme | Policy Number: 0012117

IMPORTANT INFORMATION

Who should use this claim form?

You should complete this form if:

- ☑ **Insured-** You are a registered member, official or volunteer (Insured Person) of a Club (the Insured) covered within the Bushwalking Australia Risk Protection Programme; and
- ☑ **Injured -** You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned bushwalking event/activity; and
- ☑ **Non-Medicare -** You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on the insurance section of Bushwalking Australia's website www.bushwalkingaustralia.org/insurance

What is covered?

The Bushwalking Australia Risk Protection Programme's Personal Accident cover provides some reimbursement for Non-Medicare Medical Costs and/or Loss of Income cover for 12 months from the date of injury.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Gap. Non-Medicare Medical Benefits are covered up to the limits outlined in the Cover Summary.

Please refer to www.bushwalkingaustralia.org/insurance for the Product Disclosure Statement (PDS).

How much can I claim?

Please refer to the Programme Summary available on the Bushwalking Australia website for details about how much you can claim – www.bushwalkingaustralia.org/insurance.

What is NOT covered?

The following examples demonstrate some areas not covered by the Personal Accident cover:

- ☒ Medicare items (see below);
- ☒ the Medicare Gap (see below);
- ☒ Injuries sustained whilst participating in a sanctioned Bushwalking Australia activity against medical advice.

Please refer to www.bushwalkingaustralia.org/insurance for the Product Disclosure Statement (PDS) for further details

What does "Non-Medicare" mean?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the "Medicare Gap".

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer to reimburse any part of a Medicare Item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Bushwalking National Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or www.medicare.gov.au

Please note: Some Private Health Funds may offer Medicare Gap Insurance Cover. Marsh Sport is not a Private Health Fund, nor do we offer Private Health Insurance

CLAIMS CONDITIONS

How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
   - Your claim form may be returned if there is important information missing
   - For assistance, please contact the Insurer, Accident & Health International (AHI) on +61 2 9251 8700
2. Send your completed claim form to AHI Claims Department – GPO Box 4213, Sydney, NSW, 2001 or claims@ahiinsurance.com.au within 120 days from the date of injury
   - Do not wait until your treatments have concluded before you lodge your claim
   - You can lodge your claim even if you have no out of pocket expenses
3. AHI will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information
4. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to AHI as your treatment continues (for up to 12 months from the date of injury).

What should I send with my claim?

Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to AHI.

Retain a copy - Please submit only original receipts to AHI. We recommend you retain a copy of all receipts and your Claim Form for your records.

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send AHI a copy of your Private Health rebate advice.

Claims Conditions:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to AHI within 120 days from the date of injury.

Subject to the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by AHI must be provided by you upon request and at your expense (if applicable).

Who is Accident and Health International (AHI)?

AHI issues the Personal Accident Policy for the Bushwalking Australia Risk Protection Programme (arranged by Marsh Advantage Insurance Pty Ltd. AHI manages all claims associated with this policy.

Who is Marsh Sport?

Marsh Advantage Insurance Pty Ltd is the appointed broker for the Bushwalking Australia Risk Protection Programme. As a business of Marsh & McLennan Companies (MMC), Marsh Sport is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries

SECTION A: CLAIMANT'S DETAILS

PERSONAL INFORMATION:					
Claimant's Name:	First Name		Surname		
Postal Address:	Street Address			State	Postcode
Contact Details:	Email Address		Phone Number (Bus. Hours)		
Personal Details:	Date of Birth:		Gender:	☐ Male	☐ Female
	Date of Injury:		Time of Injury:	AM/PM	
Club Name:					
Describe your injury and how it happened (please attached additional pages if required):					

INJURY RESEARCH DATA:				
Weather Conditions:	☐ Fine	☐ Rain	☐ Extreme Heat	☐ Extreme Cold
Activities	☐ Liloing	☐ Cycling	☐ Orienteering	☐ Bushwalking – day walk
	☐ Rafting	☐ Boating	☐ Rogaining	☐ Bushwalking – pack carry
	☐ Caving	☐ Training	☐ Swimming	☐ Social Activities
	☐ Canoeing	☐ Kayaking	☐ Snow Skiing	☐ Club Meetings
	☐ Abseiling	☐ Canyoning	☐ Rock Scurrying	☐ Track Hut Construction/ Maintenance

Resumption date(s):	When will you resume WORK?	N/A	N/A	
Private Health Cover:	Do you have Private Health Insurance?		☐ Yes	☐ No
If YES, what is the name of your Private Health Insurance Provider?				
Private Health Coverage:	☐ Dental	☐ Physiotherapy	☐ Ambulance	☐ Hospital
Ambulance Membership:	☐ Yes	☐ No		

PAYMENT DETAILS			
EFT Payee Details:			
Bank:			
Name on Account:			
BSB:		Account Number:	

CLAIMANT DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. The injury was sustained accidentally during a bushwalking activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.bushwalkingaustralia.org/insurance.

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).

D. You acknowledge and agree to the information contained herein (including personal information) being shared with Marsh, the insurer and the Claims Managers.

E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish AHI's representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.

F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

G. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited

Claimant's Signature*	*Parent or Guardian if under 18 years	Date:	

SECTION B: CLUB DECLARATION

CLUB DETAILS:				
Claimant's Name:	First Name		Surname	
Club Name:				
Club Contact:	Club Contact Person		Position within Club	
Contact Details:	Contact Phone Number		Email Address	
N/A:				

INJURY DETAILS:				
Date/Time:	Date of Injury:		Time of Injury:	AM/PM
N/A:	☐	☐	☐	☐
N/A:	If Applicable			
Location:	Where did the injury occur?			
N/A:	☐	☐		
	☐	☐		

CLUB DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club (as above).

B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.

C. You declare the Claimant's injury was sustained accidentally during the bushwalking activity noted above and is not a pre-existing illness or condition.

Club Representative's Signature:		Date:	

WITNESS STATEMENT:

A Statement from anyone who has witnessed your accident is required. Please have a witness provide a full description of the incident giving rise to the claimant's injury, as seen by the witness:

Witness's Name:			
Witness's Address:			
Official's Signature:		Date:	

SECTION C: LOSS OF INCOME

TO BE COMPLETED BY THE CLAIMANT:		
Do you wish to claim Loss of Income Benefits?	☐ Yes	☐ No
If NO, proceed to SECTION D		
If you are NOT claiming Loss of Income Benefits please do not complete this section. Please proceed to Section D.		
Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)?	☐ Yes	☐ No
Have you ever made previous claims in respect to a personal accident insurance policy or plan?	☐ Yes	☐ No
Have you engaged in any other income earning employment since you became injured?	☐ Yes	☐ No

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):					
Claimant's Name:	First Name		Surname		
Employer/Business:	Employer/Company Name		Contact Person		
Postal Address:	Street Address			State	Postcode
Contact Details:	Email Address		Phone Number (Bus. Hours)	Mobile	
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed	
Employment Details: (If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury)	Employee's NET weekly salary			$	
	Employee's GROSS week salary			$	
	Date Employee commenced with company.				
Injury Details:	Date employee ceased work:		Date expected to resume duties:		
Returned to Work:	Has the Employee returned to work?			☐ Yes	☐ No
	If YES, what date did the Employee return?				
Salary Received:	During the period of incapacity, has the employee received a salary?			☐ Yes	☐ No
	If YES, what for?				
Sick Leave:	☐ Yes	☐ No	From:		To:
Annual Leave:	☐ Yes	☐ No	From:		To:
Other:	☐ Yes	☐ No	From:		To:

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances.
Excludes income derived from playing sport.

EMPLOYER'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

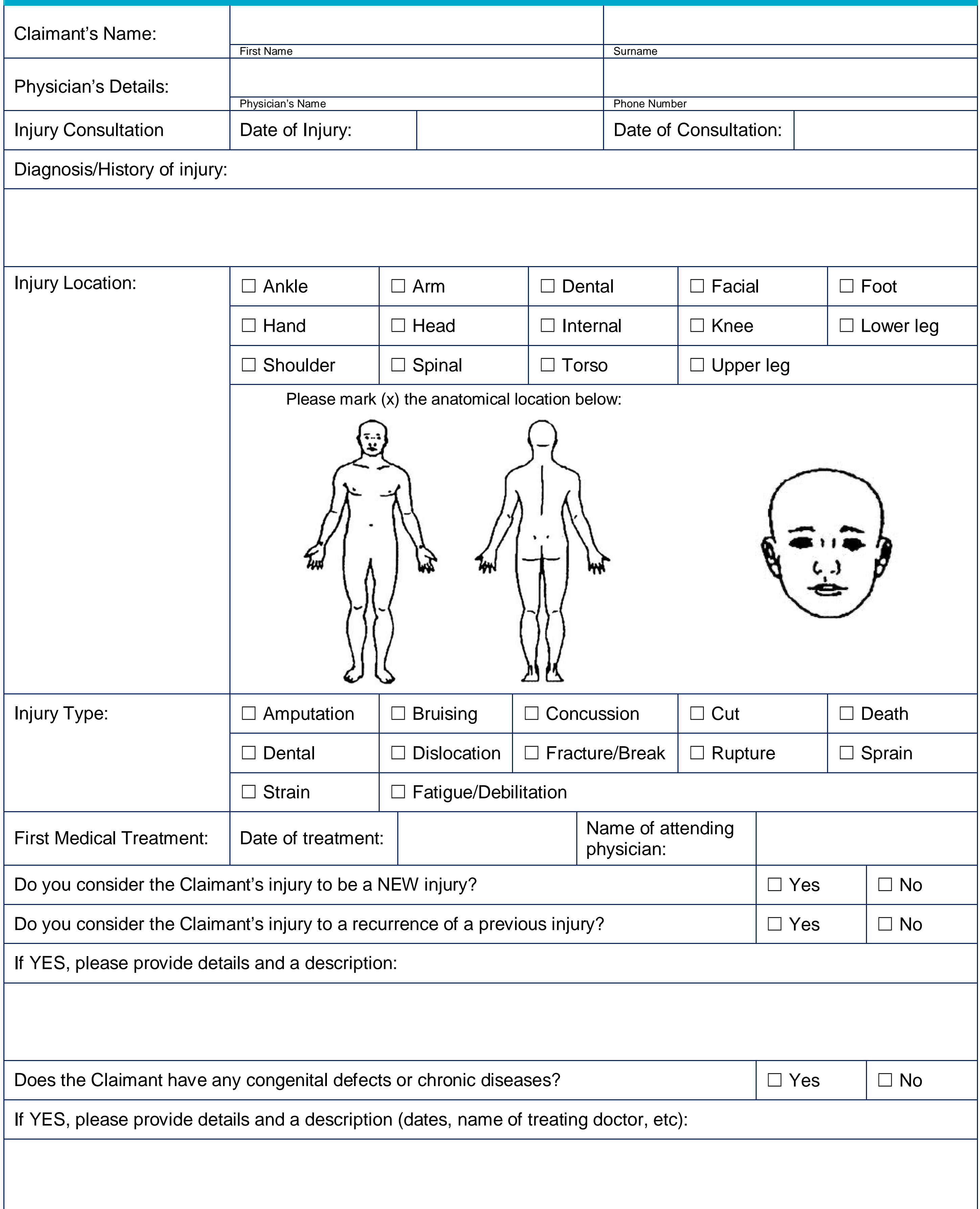
A. You are the Claimant's current employer (or accountant if the claimant is self-employed),

B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,

C. You will supply upon request any further information as required for the determination of this claim

Employer's Signature:	* Accountant's signature (if claimant is self-employed)	Date:	

SECTION D: PHYSICIAN'S REPORT



This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO MARSH SPORT

PHYSICIAN'S REPORT

Claimant's Name:	First Name		Surname	
Physician's Details:	Physician's Name		Phone Number	
Injury Consultation	Date of Injury:		Date of Consultation:	

Diagnosis/History of injury:

Injury Location:				
☐ Ankle	☐ Arm	☐ Dental	☐ Facial	☐ Foot
☐ Hand	☐ Head	☐ Internal	☐ Knee	☐ Lower leg
☐ Shoulder	☐ Spinal	☐ Torso	☐ Upper leg	

Please mark (x) the anatomical location below:

Injury Type:				
☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut	☐ Death
☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Rupture	☐ Sprain
☐ Strain	☐ Fatigue/Debilitation			

First Medical Treatment:	Date of treatment:		Name of attending physician:	

Do you consider the Claimant's injury to be a NEW injury?	☐ Yes	☐ No
Do you consider the Claimant's injury to a recurrence of a previous injury?	☐ Yes	☐ No

If YES, please provide details and a description:

Does the Claimant have any congenital defects or chronic diseases?	☐ Yes	☐ No

If YES, please provide details and a description (dates, name of treating doctor, etc):

Have you referred the patient to any other services or treatment?				☐ Yes	☐ No
If YES, please provide details below:					
Physiotherapy:	☐ Yes	☐ No	If YES, approx. number of treatments required.		
Chiropractics:	☐ Yes	☐ No	If YES, approx. number of treatments required.		
Surgery:	☐ Yes	☐ No	If YES, please provide details		
Other:	☐ Yes	☐ No	If YES, please provide details		
Has the Claimant been able to do any work since the injury occurred?				☐ Yes	☐ No
If YES, please provide details					
What date do you advise the Claimant to return to Bushwalking?					

PHYSICIAN'S DECLARATION

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form; and

B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Signature:		Date:	

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT:

I, ______________________ examined ______________________ on ______________
Medical Practitioner's Name / Claimant's Name / Date of examination

In my opinion, this person is/has been unfit to work from ______________ to ______________ Inclusive.
First day of incapacity / Last day of incapacity

Please provide any further comments in regard to your assessment of the injury/condition?

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant's injury as described on this form;

B. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature:		Date:	

SEND THE COMPLETED FORMS TO :

AHI Claims Department
GPO Box 4213, Sydney NSW 2001
Email: claims@ahiinsurance.com.au
Claims Enquiries:
Phone: 02 9251 8700

IMPORTANT INFORMATION

DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty of disclosure under the Insurance Contracts Act 1984 (Cth) to tell us anything that you know, or could reasonably be expected to know, may affect the insurer's decision to insure you and on what terms. You have this duty until the contract of insurance is entered into. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

If we ask you questions that are relevant to the insurer's decision to insure you and on what terms, you must tell us anything that you know and that a reasonable person in the circumstances would include in answering the questions. Also, we may give you a copy of anything you have previously told us and ask you to tell us if it has changed. If we do this, you must tell us about any change or tell us that there is no change. If you do not tell us about a change to something you have previously told us, you will be taken to have told us that there is no change.

You do not need to tell us anything that: reduces the risk insured, or is common knowledge, or the insurer knows or should know as an insurer; or the insurer waives your duty to tell them about.

If you do not tell us something:

If you do not tell us anything you are required to, the insurer may cancel your contract or reduce the amount it will pay you if you make a claim, or both. If your failure to tell us is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

If you are in any doubt as to the extent of the duty of disclosure or whether a piece of information ought to be disclosed, just contact your Marsh Advantage Insurance Client Risk Adviser.

MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Marsh Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Marsh') draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Marsh products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984 (Cth), the Marine Insurance Act 1909 (Cth) or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Marsh's Associated Entities, which are all businesses of Marsh & McLennan group of companies ('MMC').
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other MMC companies, insurers, reinsurers and other third party service providers (e.g. data storage providers) in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act, you must obtain it with the individual's consent.
- We will use and disclose your personal information in accordance with our Privacy Policy. By completing this form you confirm that you have read the Marsh Privacy Policy available on our website (www.marsh/com/au) and you authorise and consent to Marsh collecting, holding, using and disclosing any personal information collected by means of the enclosed document in accordance with the terms of the Marsh Privacy Policy, including for the purposes explained in this collection statement above. If there are any inconsistencies between the terms of this collection statement and the terms of the Marsh Privacy Policy, the terms of the Marsh Privacy Policy prevail to the extent of that inconsistency. You may modify or withdraw your consent at any time. If you do not give us consent or subsequently modify or withdraw your consent, we may not be able to provide you with the products or services you want.
- You can contact our Privacy Officer by:

Email – privacy.australia@marsh.com
Phone – (02) 8864 7688
Post – PO Box H176, Australia Square NSW 1215

This insurance is arranged by Marsh Advantage Insurance Pty Ltd (ABN 31 081 358 303, AFSL 238 369) ('MAI'). MAI are not the insurer. The advice in this form is general advice only. To help you decide if the cover suits you, please read the Product Disclosure Statement. Please contact MAI to request a copy or for further information.

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