OAMPS Sports Risk Management

CLAIM FORM

Basketball Australia Insurance

OAMPS Insurance Brokers

Sports Insurance Claim Form

1. Please complete Parts 1,2,3,4,5,6,7 and 8 of this claim form (pages 2 and 3), plus the injury data collection questions on pages 5 and 6
2. Ask Your doctor to complete the 'Medical Statement' (pages 7 and 8)
3. If Your claim is for loss of earnings:
   (a) Ask Your employer to complete Part 9 (page 4). 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
4. An authorised official of Your club must complete Part 10 (page 4)
5. Please refer to 'Notes for claimants' on page 9

The Association

1

Sport played

Regional body

Association name

Club

Team

Age group

Grade ☐ Seniors ☐ Reserves ☐ (if applicable)

The Member

2

Name

Address

P/code

Phone Work Mobile

Email Address

Occupation

Date of Birth .... /..... . ..... /..... . ..... Sex: Male ☐ Female ☐

Registration number

Details of the Member's Disability or Injury

3

What is the nature of Your injury?

What body part/s has been injured?

Is it a recurrence of a previous injury? Yes ☐ No ☐

How did it happen?

Where were You when it happened?

Type of location Sportsground ☐ Gymnasium ☐ Swimming pool ☐ Other ☐

If 'Other' please describe

When did the injury occur? Date: .... /..... . ..... /..... . ..... Time:

What were **You** doing? Playing a match ☐ Warm up ☐ Training ☐ Other sport ☐ Gradual onset ☐

What was the event? Competition ☐ Regular training ☐ Training camp ☐ Private training ☐ Other ☐

If 'Other' please describe

Details of the Member's treatment

4 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

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

5 Were **You** suffering any previous medical condition? Yes ☐ No ☐

If 'Yes', give details of the condition

Have **You** ever made a claim under a sports' injury or personal accident insurance policy? Yes ☐ No ☐

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

P/code

Details of the Member's insurance

6 Are **You** a member of a health fund Yes ☐ No ☐

If 'Yes', what type of membership do **You** have? Hospital cover only ☐ Ancilliary cover only ☐ Hospital plus ancilliary 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? Yes ☐ No ☐

If 'Yes', please show name and address of insurer

P/code

Drugs and intoxicating liquor

7 Were **You** under the influence of any drug or intoxicating liquor when the disability or injury took place Yes ☐ No ☐

If 'Yes", please give details

Have You taken any performance enhancing drugs? Yes ☐ No ☐

The Member's declaration

8 By signing this claim form I declare that

a. All the information that I have given in this form is correct
b. I authorise any doctor, hospital or other person who has treated me to provide OAMPS Insurance Brokers Ltd. or its representative with any medical records for any illness or injury I have suffered.
c. I authorise my employer to provide OAMPS Insurance Brokers Ltd. or its representative with details of my salary and working hours.
d. I agree that a photocopy of this authorisation will be accepted as valid.
e. 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** or their guardian if the member is under 18 years

Signature

Date .... /..... . ..... /..... . .....

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

9

Employer's name

Employer's address

P/code

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) $ p.w.

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 .... /..... . ..... /..... . .....

The Club's declaration

10 Must be completed by the club Secretary or Treasurer

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

I .....
Secretary or Treasurer

of .....
Name of club and association

Confirm that .....
Member's name

Sustained the injuries resulting in this claim on

..... at .....
Date time

While playing or training for .....
Team

against .....
Opposition Team

or while taking part in .....
Activity

against .....
Opposition Team

at .....
Place of game or activity

The first consultation with a doctor for this injury was on

.....
Date

at .....
Address of doctor

Signature

Date .... /..... . ..... /..... . .....

Club mailing address

P/code

Phone number

State Association/OAMPS Office Use Only

Player Registration Number .....

Signed .....

Position .....

State Association Stamp Where Applicable

Injury data collection

OAMPS Insurance Brokers Ltd is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. OAMPS Insurance Brokers Ltd, 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

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 ☐
1st Quarter ☐ 2nd Quarter ☐
3rd Quarter ☐ 4th Quarter ☐
Cool Down ☐

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

If 'Other', please provide details

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

If 'Other', please provide details

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

If 'Other', please provide details

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

If 'Other', please provide details

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

If a collision injury, what did You collide with?
Ground ☐ Equipment ☐ Player ☐
Other Structure ☐

If 'Other', please provide details

What was Your activity leading to the injury?
Landing ☐ Jumping ☐ Twist/Turn ☐
Side Stepping ☐ Starting ☐ Stopping ☐
Running ☐ Applying Tackle ☐ Being Tackled ☐
Receiving Ball ☐ Passing/Throwing ☐ Hitting ☐
Kicking ☐ Scrum ☐ Ruck ☐
Maul ☐ Other ☐

If 'Other', please provide details

Was protective equipment, tape or support being worn on the injury site?
Yes ☐ No ☐

If yes, please provide details
Taping ☐ Protective Equip. ☐ Other Support ☐

If protective equipment, please provide details

If other support, please provide details

How did the injury severity affect Your playing?
Unable to Continue Playing ☐
Continued to Play After Treatment ☐
Continued to Play 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 sports trainer present at the game?
Yes ☐ No ☐ Unknown ☐

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

Hospital		Doctor		Physiotherapist	
Dentist		Other			

If 'Other' please provide details

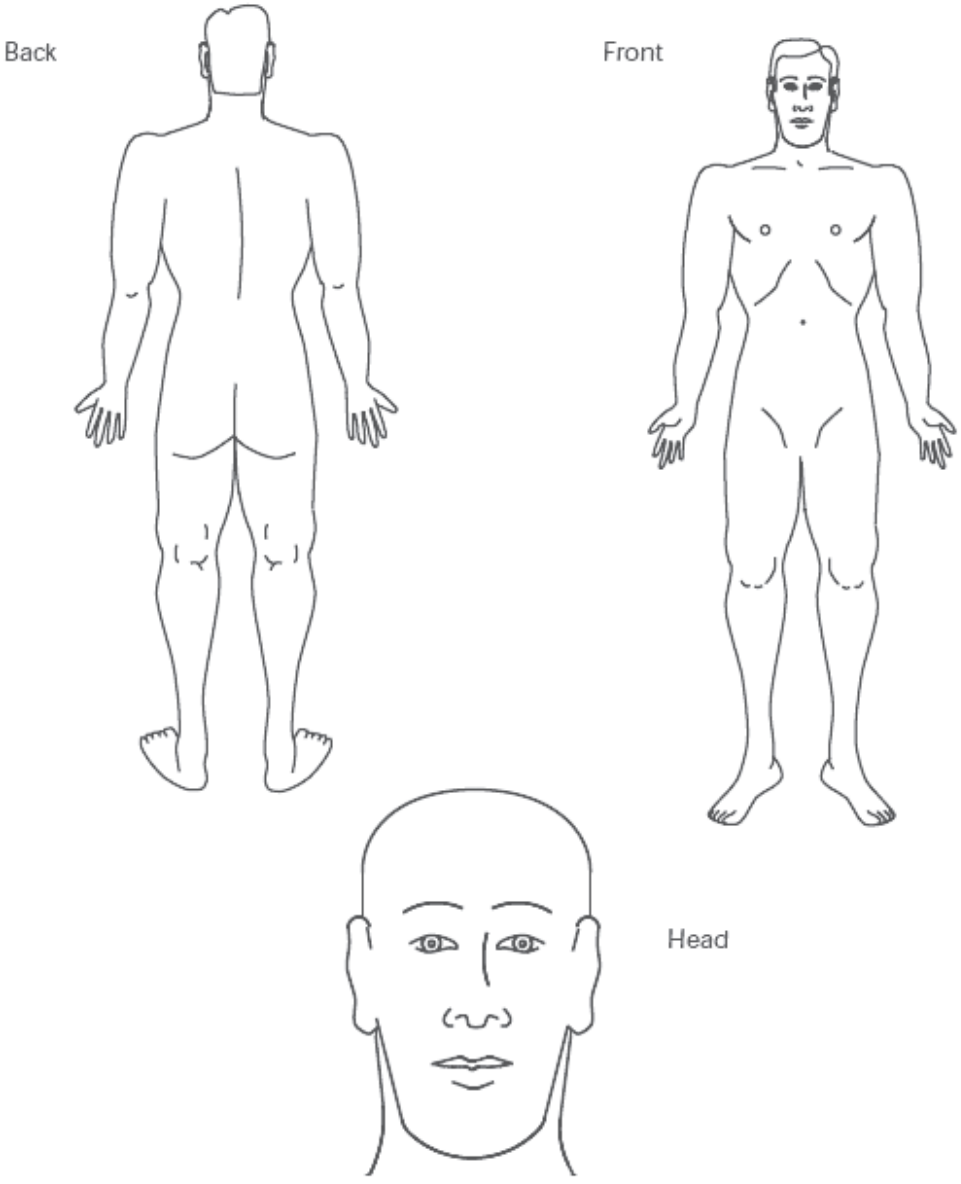
If immediate off site treatment was necessary,

Ambulance		Private Vehicle		Other		

What mode of transport was used?

If 'Other', please provide details

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



Medical statement

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

The Association and Club

Association name

Club name

Type of sport

The Member

Name

Address

P/code

Age

Gender

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? Yes No

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 Date: .... /..... . ..... /..... . .....

Has condition improved? Yes No

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. .... /..... . ..... /..... . .....

P/code

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

Cardiac-circulatory

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

Blood pressure

Circulatory disorder – please describe

Visual

Is the patient totally or industrially blind? Yes ☐ No ☐

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? Yes ☐ No ☐

What are the rehabilitation prospects?

Orthopedic

Please report findings of specialist if referred?

Neurological

Please report findings of specialist if referred?

Prognosis

Remarks

Please apply doctors name stamp below

Signature

Date .... /..... . ..... /..... . .....

Degree

Name of Doctor (please print)

Address

P/code

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

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 our office within 30 days of your injury. Do no wait for all your medical accounts. Forward them to us as you receive them.**
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 OAMPS 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 to your complaint to the Insurance Brokers Disputes Ltd. (IBD). Each of the licenced entities subscribes to the external facility for the handling of complaints. You can refer your complaint to an IBD Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

If either you or OAMPS reject the IBD Case Manager's finding and the dispute remains unresolved, it will be referred to the IBD's Referee whose decision is binding on us (but not on you). Further information about the IBD is available for all OAMPS Insurance Brokers Lid offices.

Contacts

Claims forms should be sent to the OAMPS Insurance Brokers office servicing your association. Details can be found via www.oamps.com.au, by calling our national sports insurance number 1800 SPORT 1 (1800 776 781) or at our State and Territory capital city offices listed below:

Adelaide
168 Greenhill Road
Parkside, Adelaide, SA 5063
T: (08) 8172 8000
F: (08) 8172 8100

Brisbane
Lvl 2, 8 Gardner Close
Milton, Brisbane, QLD 4064
T: (07) 3367 5000
F: (07) 3367 5100

Canberra
Ground Floor, 10 Geils Court
Deakin ACT 2600
T: (02) 6283 6555
F: (02) 6283 6556

Darwin
Lvl 2, 71 Smith Street
Darwin, NT 0801
T: (08) 8942 5000
F: (08) 8942 5050

Hobart
Lvl 4, 85 Macquarie Street
Hobart, TAS 7000
T: (03) 6235 1222
F: (03) 6235 1221

Melbourne
289 Wellington Parade South
East Melbourne, VIC 3002
T: (03) 9412 1555
F: (03) 9412 1666

Perth
Lvl 1, 21 Teddington Street
Burswood, WA 6100
T: (08) 6250 8300
F: (08) 6250 8400

Sydney
Lvl 4, 2-12 Macquarie Street
Parramatta, NSW 2150
T: (02) 8838 5700
F: (02) 8838 5701