Sport | Athlete Protection

Volleyball Australia Athlete / Member

Sports Injury Rehabilitation Claim Form

Arthur J. Gallagher

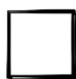
BUSINESS WITHOUT BARRIERS™

How to claim:

Arthur J. Gallagher is committed to Safer Sport. Here we outline the most efficient way for you to make a claim under the Volleyball Australia (VA) Athlete Injury Rehabilitation Insurance Policy.

There are a number of important sections for completion and verification by differing experts, please pay attention to each step and call Arthur J. Gallagher claims on our VA Claims Hotline (07 3367 5228) for any assistance.

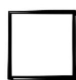
1. Complete the Member Injury Details Section ('Your') relates to you as the registered athlete making the claim) Pages 3-5
    - For claims relating to loss of income, please have your employer complete Section 8, page 5. If you are self-employed please have Your accountant complete these details
    - Forward a medical certificate every four weeks if Your disability is continuing


Completed Step 1

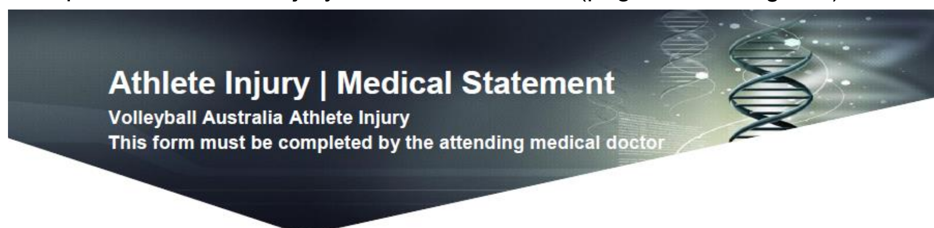
2. Have your State Association, to which you are registered to, complete the Declaration Section on page 6.

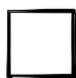
Completed Step 2

3. Complete the Athlete Injury Data Collection Section (allowing VA and AJG to remain proactive in risk prevention and management) Page 7 through 9.
    - Please ensure the Disclosure Statement and Privacy Consent form, on Page 10, have been signed. To receive reimbursement via Electronic Banking, please complete Page 11.


Completed Step 3

4. Ask Your treating doctor to complete the 'Athlete Injury Medical Statement' (pages 10 through 12)




Completed Step 4

5. Please refer to 'Notes for Injured Athletes / Members' on page 15, and **return all completed sections to:**
    - **AJG VA Claims, GPO Box 1113, Brisbane 4001** or **Sport.Brisbane@ajg.com.au**

Athlete Injury | Member Injury Details

1. The Association (Your team details)

League: ____

Club Name: ____

Team Name: ____

Division (please tick): ☐ Mens ☐ Mixed ☐ Juniors

2. The Member (Your details)

Name: ____

Address:_______________________ State: _________ Postcode: _________

Phone: (Work): ____________________ Mobile: ____________________

Email Address:____

Occupation: ____

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

3. Details of Your Disability or 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? ____

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

If 'Other' please describe: ____

When did the injury occur? ____ / ____ / ____ Time: ____________________

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

If 'Other' please describe: ____

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

If 'Other' please describe: ____

4. Details of Your 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 Your 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 Your personal 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. Drugs and intoxicating liquor

Were **You** under the influence of any drug 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. Your employment details (Must be completed by pay clerk/paymaster)

Employer's name: ____

Employer's address: ____

____

____ State: ______________ Postcode: ______________

Phone number: ____

Email:____

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? ____ / ____ / ____

What is the name of **Your** pay clerk?____

What is **Your** pay clerk's phone number? ____

What is **Your** pay clerk's email address? ____

Signature of pay clerk / paymaster: ____ Date: ____ / ____ / ____

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)***

9. The States declaration

Must be completed by your Affiliated State Management.

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

I ____ *State Manager*

of ____ *Affiliated State*

Confirm that ____ *Member's name*

Sustained the injuries resulting in this claim on:

_______________ / __________ / _____________ *Date* at ______ : _____ am / pm *Time*

While playing or training for ____ *Team / Club Name*

against ____ *Opposition Team*

or while taking part in ____ *Activity*

against ____ *Opposition Team*

at ____ *Place of game or activity*

Signature: ____ **Date:** ____ / ____ / ____

State mailing address: ____

____ State: _______________ Postcode: _______________

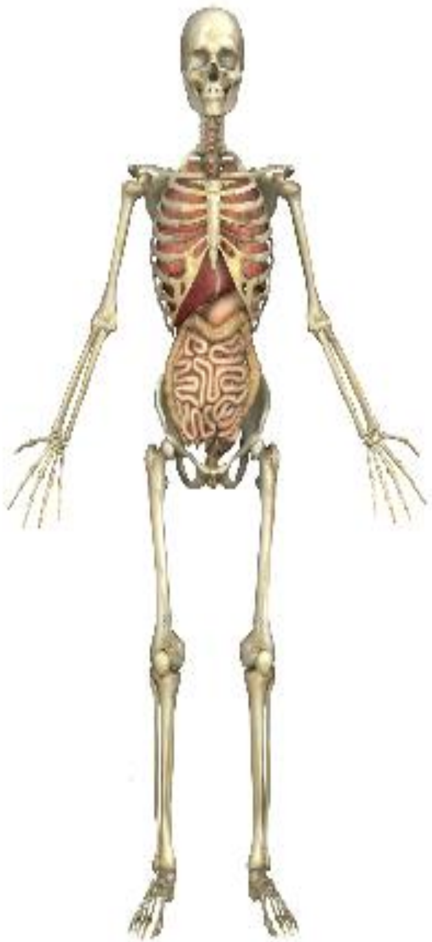
10. Injury data collection

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 Volleyball Australia and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

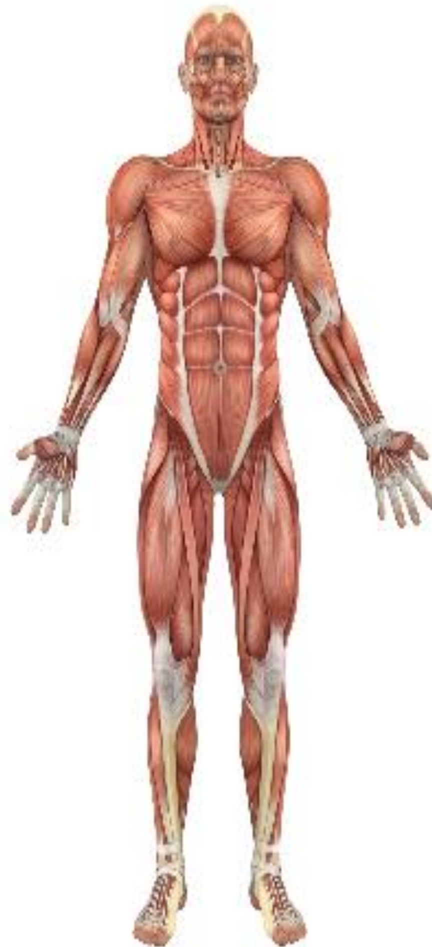
What was **Your** role at the time of Your injury?	☐ Participant ☐ Voluntary Worker	☐ Coach ☐ Spectator	☐ Umpire ☐ Other	☐ Other Official	
If 'Other' please provide details:					
What position were you playing at the time of the injury?	☐ Right Side Hitter ☐ Libero	☐ Middle Blocker ☐ Outside Hitter	☐ Opposite ☐ Interchange	☐ Setter ☐ Not Playing	
If not playing, please provide details					
Did you have possession of the ball at the time of injury?	☐ Yes	☐ No			
At the time of your injury, how far into your volleyball experience were you?	☐ 1st Match	☐ 2nd – 5th Match	☐ 2nd Season in a row	☐ Other	
If 'Other' please provide details:					
Was a penalty called at the time of your injury?	☐ Yes	☐ No			
If yes, was the penalty awarded against:	☐ You	☐ Opposing Player	☐ Both Players		
What is your estimated absence from playing due to your injury?	☐ No Absence ☐ More than 3 Weeks	☐ Less than 1 Week	☐ 1 – 3 Weeks		
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 ☐ 5th Set	☐ 1st Set ☐ Cool Down	☐ 2nd Set ☐ Training	☐ 3rd Set	☐ 4th Set
On what surface were **You** participating?	☐ Grass ☐ Woodern Floor	☐ Synthetic ☐ Sand	☐ Concrete / Bitumen ☐ Other	☐ Road	☐ Gravel
If 'Other' please provide details:					
What was the condition of the surface?	☐ Dirty / Dusty	☐ Hard	☐ Normal	☐ Wet	☐ Muddy ☐ Other
If 'Other' please provide details:					

What were the weather conditions as the time of injury?	☐ Fine ☐ Light Rain ☐ Heavy Rain ☐ Indoor Mist ☐ Other
If 'Other' please provide details:	
What were the temperature conditions at 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 ☐ Fence / Signage ☐ Equipment ☐ Player ☐ Other Structure
If 'Other' please provide details:	
What was **Your** activity leading to the injury? (please tick more than one if applicable)	☐ Landing ☐ Jumping ☐ Twist/Turn ☐ Spiking ☐ Starting ☐ Stopping ☐ Side Stepping ☐ Running ☐ Blocking ☐ Receiving ☐ Digging ☐ Serving ☐ Other
If 'Other' please provide details:	
Was protective equipment, tape or support being worn at time of injury?	☐ 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 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 / first aid officer 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, what mode of transport was used?	☐ Ambulance ☐ Private Vehicle ☐ Other
If 'Other' please provide details:	

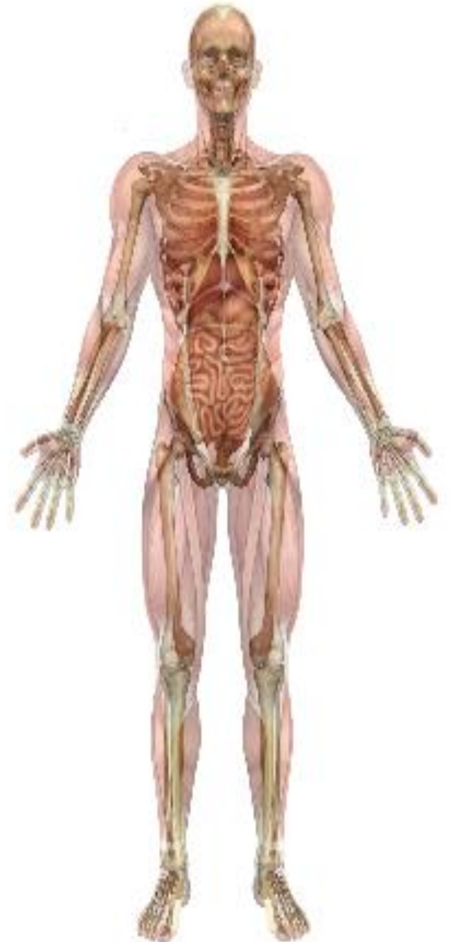
Please indicate the site of your injury on the appropriate diagram below:



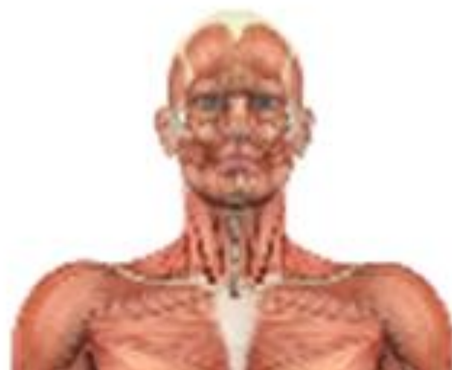
Internal



Front of body



Rear of body



Facial

Disclosure Statement and Privacy Consent

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** or their guardian if the member is under 18 years

Signature: ____________________ **Date:** ____ / ____ / ____

Electronic Banking Details (to be completed by the injured person)

I/We hereby authorise that all future payments be made via Electronic Funds Transfer to the following bank account:

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Bank Name: ____________________

Branch Address: ____________________

Account in the Name of: ____________________

Type of Account: ____________________

BSB Number: ☐☐☐-☐☐☐ (6 digits)

Account Number: ____________________

Conditions of this agreement:

- I/We will be responsible for notifying Arthur J. Gallagher in writing of any changes in the above particulars. Until receipt of such notifications, Arthur J. Gallagher shall process all payments in accordance with the above particulars.
- I/We warrant that the bank account details so provided are not false and comply with all applicable laws.
- Arthur J. Gallagher has the right to accept the authority of the undersigned as conclusive evidence of that persons authority to execute this agreement on behalf of the supplier. Arthur J. Gallagher is under no obligation to verify the authority of the undersigned on the Bank Account details.
- I/We acknowledge that it is not practicable for Arthur J. Gallagher to keep banking details confidential, to the extent that these will be available to Arthur J. Gallagher in carrying out their normal duties in paying accounts.
- Arthur J. Gallagher will not be responsible for any delays in the payment of errors due to factors outside the reasonable control of Arthur J. Gallagher (including but not limited to delays and errors in the banking system).
- Arthur J. Gallagher reserves the right at any time to terminate or suspend this direct credit payment metod and to pay by cheque or any other manner which Arthur J. Gallagher may determine.

Name (please print): ____________________

Signature: ____________________ Date: ______ / ______ / ______

PERSONAL INFORMATION PROTECTION STATEMENT

Personal information we collect from you on this Electronic Funds Transfer Form will be used by Arthur J. Gallagher staff for the purpose of making payments to you in respect of your claim. Your personal information will be used for the primary purpose for which it is collected, and will not be disclosed to third parties. Your personal information will be managed in accordance with the National Privacy and Data Protection Act 2014.

Athlete Injury | Medical Statement

Volleyball Australia Athlete Injury
This form must be completed by the attending medical doctor

Medical Statement

Please note: Any charge issued for completion of this form will not be reimbursed by the insurer.

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 injured athletes / members

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 5 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 Arthur J. Gallagher. 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** or telephone 1800 240 432.

Claims Handling

Claims are processed at Arthur J. Gallagher Brisbane office (refer Brisbane address below). To maximize claims handling efficiency send your completed claim form and documentation direct to that office.

Arthur J. Gallagher Capital City Offices

Adelaide

168 Greenhill Road
Parkside, SA 5063
T: 08 8172 8000
F: 08 8172 8100
adelaide@ajg.com.au

Brisbane

GPO BOX 1113,
BRISBANE 4001

T: 1800 776 780
F: 07 3367 5100
sport.brisbane@ajg.com.au

Canberra

Ground Floor, 10 Geils Court
Deakin ACT 2600
T: 02 6283 6555
F: 02 6283 6556
canberra@ajg.com.au

Darwin

Level 2, 71 Smith Street
Darwin, NT 0800
T: 08 8942 5000
F: 08 8942 5050
darwin@ajg.com.au

Hobart

137 Harrington St
Hobart, TAS 7000
T 03 6235 1222
F 03 6235 1221
hobart@ajg.com.au

Melbourne

289 Wellington Parade South
East Melbourne, VIC 3002
T: 03 9412 1555
F: 03 9412 1666
melbourne@ajg.com.au

Perth

Level 1, Teddington Road
Burswood, WA 6100
T: 08 6250 8300
F: 08 6250 8400
perth@ajg.com.au

Sydney

Level 4, 2-12 Macquarie Street
Parramatta, NSW 2150
T: 02 8838 5700
F: 02 8838 5701
sydney@ajg.com.au

Arthur J. Gallagher National Branch Network

Locally focused. Nationally resourced. Internationally represented.

Direct to your AJG Sport branch

1800 SPORT 0

www.ajg.com.au/va

Arthur J. Gallagher & Co (Aus) Limited. ABN 34 005 543 920.
AFSL 238312.

Arthur J. Gallagher
BUSINESS WITHOUT BARRIERS™

Sport @ Arthur J. Gallagher
LOVE SPORT | KNOW SPORT | PROTECT SPORT