Sports insurance claim form

Harness Racing
Sport | Insurance solutions

Claim form – Harness Racing

1. Please complete Parts 1 - 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 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 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.

6. To maximise claims handling efficiency send your completed claim form to OAMPS Parramatta office. Refer to the bottom of page 9 for the Parramatta office address.

1: The policy holder

Name: ____________________________________________________________

Club: ____________________________________________________________

2: The Member

Name: ____________________________________________________________

Address: ____________________________________________________________

_________________________________________ State: ____________________ Postcode: ______________________

Phone: (Work): ____________________________________________________ Mobile: ________________________________

Email Address: ______________________________________________________

Occupation: _________________________________________________________

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

Licence Number (if known): __________________________________________

Your Australian Tax File Number: _____________________________________

*Your Australian Tax File Number will be kept safe and secure and only used for tax related purposes. If you do not wish to provide your Tax File Number, we will then have to apply the highest applicable tax rate to any taxable benefits paid to you for this claim.*

3: Details of the Member’s 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? ______________________________________________________

______________________________________________________________

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Address where it happened?

Type of location:  Public Race Track ☐  Training Track ☐  Stables Owner/Trainers property ☐  Other ☐

If ‘Other’ please describe:

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3: Details of the Member’s Disability or Injury (continued)

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

What were **you** doing?  Driving Gig ☐  Riding On Back of Horse ☐  Attending to Horse ☐
Loading/Unloading Horse from Trailer ☐  Other ☐

If ‘Other’ please describe: __________________________________________________________

What was the event?  Official Race ☐  Trial ☐  Private Training ☐  Trackwork Training ☐  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? ________________________________________________________________

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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: 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: The Member’s declaration

By signing this claim form I declare that:

a) I hereby authorise any hospital, physician, insurer, health insurance commission, employer or other person who has attended me to supply Lumley Insurance or its representative with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all my hospital and/or medical records, including any and all relevant financial information and details of any paid entitlements with respect to the claimed injury or sickness.

b) I agree that a photostat and/or facsimile copy of this authorisation shall be considered as effective and valid as the original.

c) 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 claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery there under or in respect of past or future claims shall be forfeited.

Must be completed by the injured Member or their guardian if the member is under 18 years

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Signature: ____________________________________________________________ Date: ___/___/___

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: Harness Racing NSW declaration

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 ________________________________________________________________ NSWHR employee

Confirm that (Name of Member and Licence Number)________________________________________

Sustained the injuries resulting in this claim on:

Date at ____________________________ Time ____________________________

While (description of activities) __________________________________________

At (place) ________________________________________________________________

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

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Date

at  

Address of doctor

Signature:  

Date:  

Mailing address:  

State:  

Postcode:  

Phone number:  
# 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?

- [ ] Driver
- [ ] Licenced trainer
- [ ] Stable hand
- [ ] Other

If ‘Other’ please provide details:

## If incident occurred at Public Race Track, where did it occur?

- [ ] Loading/Unloading Horse
- [ ] Stable
- [ ] On Track
- [ ] Marshalling Area
- [ ] Parade Ring
- [ ] Other

If ‘Other’ please provide details:

## If incident occurred at owners/trainers property, where did it occur?

- [ ] Loading/Unloading Horse
- [ ] Paddock
- [ ] Stables
- [ ] On training track
- [ ] Other

If ‘Other’ please provide details:

## On what surface did the incident take place?

- [ ] Sand
- [ ] Grass
- [ ] Bare dirt
- [ ] Gravel
- [ ] Concrete / Bitumen
- [ ] Other

If ‘Other’ please provide details:

## What was the condition of the surface?

- [ ] Normal
- [ ] Soft
- [ ] Hard
- [ ] 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
- [ ] Pre-Existing at the start of the activity

## If you personally collided with/were struck by something, what was it?

- [ ] Own Horse
- [ ] Another Horse
- [ ] Ground / Track
- [ ] Gig
- [ ] Fence
- [ ] Other

If ‘Other’, please describe

---

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What protective equipment was being worn at the time of the injury?

☐ None    ☐ Helmet    ☐ Safety Vest    ☐ other

If 'Other', please describe

How did the injury severity affect the activity you were involved in at the time?

☐ Unable to continue    ☐ Continued 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:

Were first aid / medical personnel present at the activity?

☐ 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:
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Back

Front

Head
Medical statement

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

The policy holder

The policy holder: __________________________________________________________

Club name: ______________________________________________________________

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 participant 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

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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
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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, ___ / ___ / ___
note and address of that doctor

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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: ___ / ___ / ___

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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: _______________________

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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 our office within 30 days of your injury. Do not 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 & Co (Aus) Limited 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.
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Arthur J. Gallagher Capital City Offices

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F: 08 8172 8100
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Toowong Qld 4066
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F: 07 3367 5100
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Canberra
Ground Floor, 10 Geils Court
Deakin ACT 2600
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F: 02 6283 6556
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Arthur J. Gallagher Insurance Brokers, AFSL 238312. To the extent that any material in this document may be considered advice, it may only be considered general advice as it does not take into account your personal objectives, needs or financial situation. Arthur J. Gallagher urges you to read the relevant policy wording and consider whether any products are appropriate for your situation before making a decision to acquire insurance.

Direct to your nearest branch
1800 240 432
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