# Group Personal Accident Insurance

# Claim Form

**Completed claim forms must be sent to;**

**Network Insurance Group**
PO Box 877
Collins Street West
Melbourne ,VIC 8007
Tel: 03 8420 8777
Email: sailing@networksteadfast.com.au

This insurance cover is underwritten by AIG Australia Limited (“AIG Australia”)
ABN 93 004 727 753 | AFSL 381686

## Summary of Cover

The following is intended as a summary only. Please use the links below to visit Network Insurance Group – Australian Sailing webpages to view full details of the policy;

- Policy Wording
- Policy Schedule
- Policy Endorsements

## Who is insured?

The Australian Sailing Group Personal Accident Insurance policy provides cover to the following insured persons if they suffer an injury or accident while participating in an Australian Sailing Affiliated Yacht Club's sailing and training activities:

- Financial members (including Sail Pass members) of Australian Sailing Affiliated Clubs,
- Discover Sailing Course Participants,
- Voluntary workers, Directors and Committee members of Australian Sailing Limited,
- Guests/Temporary Members of an Australian Sailing Limited Affiliated Club

## Non-Medicare Medical Expense

The Australian Sailing Group Personal Accident Insurance policy reimburses up to 100% of Non-Medicare medical expenses not recoverable from private health insurance up to a maximum of $5,000 subject to a $50 excess. Medical Expenses covered by Medicare are not covered by policy.

The following table is intended to help understand what expenses that are covered and not covered by the Non Medicare Medical Expenses benefit under the policy:

| Expenses Covered | Expenses Not Covered |
|---|---|
| Physio (sub-limit $750) / Chiropractor | Surgeons, |
| Dental (up to $5,000 - see Table of Benefits in Policy Endorsements) | Anaesthetists |
| Ambulance | Doctors, |
| Theatre fee | X-rays |
| Private hospital bed | Other accounts which are partly covered by Medicare (Medicare Gap) |

## Other Benefits

Limits apply - Please refer to Policy Schedule, Policy Wording and Policy Endorsements for coverage detail;

### Loss of Income

Pre-Injury Salary, if prevented from working in your Occupation

### Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability.

### Funeral Benefit

Will pay for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

### Broken Bones

Will pay up to $5,000 any one accident.

### Student Tutorial Costs

Reimburses home tuition by a qualified tutor if the Injury stops the Insured Person from going to their external tutor outside the home .

### Domestic Help Benefit

Reimburses licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependent children.

# How to Make a Claim

Please find attached a claim form. Before lodging this form, please ensure all relevant sections are fully completed. Failure to complete all sections of this form properly may delay settlement of or rejection of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as reasonably possible You do not have to wait until after you have completed treatment for your injury to lodge your claim form.
2. Sections 1-2 should be fully completed by the claimant for all claims.
3. Section 3 (Declaration by Association/Club) needs to be completed for ALL claims by the Club where you are a member.

   **Note:** This section should be submitted to your club to complete once you have fully completed all sections of the claim form. This section is intended to confirm you are a member of and Australian Sailing Affiliated Club and that your injury occurred during an Australian Sailing affiliated yacht club sanctioned activity.
4. Section 4 must be signed by you for the claim to be considered.
5. Section 5 should only be completed by you if claiming Non Medicare Medical Expenses (including Physio/ Dental).

   **Please attach** all itemised receipts (be sure to copy them before you claim with your health fund as they will retainthe original). Hospital claims must be accompanied by an itemised Invoice, not just the estimate. If treatment or a cost incurred is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.
6. Section 6 should only be completed if you are claiming Loss of Weekly Income (including Student Tutorial/ Home Help).

   **Please attach** a minimum of 3 months of payslips prior to the date of injury.

   If claiming Student Tutorial or Home help, **please attach** receipts for expenses incurred.
7. Section 7 & 8 must be completed and signed by you to enable claim settlement into your nominated bank account.
8. Section 9 (Loss of Income Declaration) needs to be completed by Your employer/ accountant if claiming for Loss of Weekly income.
9. Section 10 (Attending Physician Statement) needs to be completed for ALL claims by the attending physician who treated your injury.
10. Once you have completed your claim form, please forward to:
    **Network Insurance Group,**
    PO Box 877 Collins Street West, Melbourne ,VIC
    sailing@networksteadfast.com.au
    Tel: 03 8420 8777
11. Once your claim is registered, you will submit ongoing invoices to AIG Australia Limited (details to be provided). We can also be reached on the above contact details should you wish to make enquiries relating to the completion of this claim form or the progress of your submitted claim.

# CLAIM FORM:

## Australian Sailing Sporting Personal Injury Insurance

### Section 1: Claimant Details (To be completed by the claimant)

| | | | |
|---|---|---|---|
| Claimants Name | | Date of Birth | |
| Club Name | | Club Membership Number | |
| Vessel Class | | Training Program Name | |
| Occupation | | Gender | |
| Address | | Post Code | |
| Email | | Phone | |

Please tick the category applicable to you:

☐ Race Participant ☐ Training Participant ☐ Official ☐ Volunteer / Member ☐ Other

If other please specify _____

### Section 2: Accident Details (To be completed by the claimant)

| | |
|---|---|
| Describe how the accident happened | |
| Describe your Injury: | |
| When did your accident Occur? | Date:_____Time: _____ am/pm |
| What was your activity at the time of the Incident? | ☐ Officially Organised Training<br>☐ Officially Organised Competition<br>☐ Social or Private Competition<br>☐ Sanctioned fundraising / social event<br>☐ Travelling to and from activity |
| Please provide Name and State of the club providing the sailing activity you were participating in: | |

| | | |
|---|---|---|
| Please provide the location of where the injury occurred | | |
| State the name of any one witness of the injury: | | |
| Person to whom this 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? | Yes / No | |
| If admitted into hospital; | Name of Hospital | How long were you there? |
| | | |
| Name of person who gave treatment: | | |
| Have you ever had this injury or similar injuries in the past? | Yes / No | |
| If yes, When did this occur | | |
| Please provide details | | |

## Section 3 - Declaration by Association/Club

**The following section must be completed by a club official representing the Australian Sailing Affiliated Yacht Club / Class Association who was hosting the event you were participating in at the time of the injury.**

Name of Association/Club:_____

Name of Official Making this Statement:_____

Official's Position:_____Phone:_____

Email:_____

Address:_____Postcode:_____

Do you have any comments in relation to this claim?_____Yes / No _____

If yes, please specify:_____

☐ I, the above mentioned Australian Sailing or Club Official, confirm that the claimant was a registered and Financial member of this club 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.

☐ I, confirm that the claimed accident occurred at an Australian Sailing Affiliated club premises, including an organised event; OR at an event that was organised by or sanctioned by World Sailing or one of World Sailing's Member National Authorities, including but not limited to Australian Sailing.

Signature of Association/Club Official:_____Date: _____

## Section 4: Declaration Agreement and Authorisation by Claimant

I_____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 or my policy may be cancelled. I herebyauthorise AIG Australia Limited to collect and disclose information about me or the parties referenced in the privacy notice below 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 any taxation returns and assessments.

### Privacy notice

AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including dataanalytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Failure to disclose information required may result in AIG not being able to administer or declining the claim.

AIG may disclose your information to:

- your or our agents, AIG related entities, reinsurers, contractors or third party providers providing services relatedto the administration of the claim;
- assessors, third party administrators, emergency providers, retailers, medical providers or travel carriers, or anythird parties or insurer from whom AIG seeks recovery related to the claim;
- entities to which AIG is related and third party providers for data analytics functions; and
- Government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

Some of these entities may be located overseas, including in United States of America, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which you have a claim and such other countries as may be notified in ourPrivacy Policy from time to time.

Our Privacy Policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicableprivacy principles and how AIG will deal with such a complaint.

### Consent

I consent to AIG collecting, using and disclosing personal information as set out in this notice. If I have provided or will provide information to AIG about any other individuals, I confirm that I am authorised to disclose his or her personal information to AIG and also to give this consent on both my and their behalf.

Signature of Claimant (Or Legal Guardian if Under 18 years of age) _____

Date _____

## Section 5: Non Medicare Medical Expenses

(only complete this section if claiming for Non Medicare Medical expenses)

**NOTE:** 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 | Yes / No |
| Do you have hospital cover? | Yes / No |
| Are you covered for Extras incl. Physio etc? | Yes / No |

Itemised accounts and receipts must be submitted together with details of Benefits from any Private Health Insurance (attach extra sheet if more space is required)

| Name of provider | Name of Service (i.e. dental) | Date of Service | Charge | Private Health Fund Recovery (if applicable) | Amount Claimable |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Section 6: Loss of Income / Student Tutorial / Home Help

(only complete this section if claiming for loss of income)

**Advise below when you did (or expect to):**

| | | | |
|---|---|---|---|
| Cease work/normal activities: | | Resume work/normal activities: | |
| Cease training: | | Resume training: | |
| Cease participating: | | Resume participating: | |
| Can compensation be claimed under worker's compensation or any other insurance including Loss of Income? | | | |
| Have you ever made any previous claims in respect to personal accident insurance or any other similar insurance? | | | |
| Have you engaged in any other income earning employment since you have been injured? | | | |

## Section 7: Method of Payment

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account.

**BANK ACCOUNT DETAILS – Please complete the following:**

Bank: _____

Account Name(s): _____

BSB Number: _____ Account Number: _____

## Section 8: Payment Declaration

I hereby authorise AIG Australia Limited 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 AIG Australia Limited has instructed its bank to credit the nominated account and that we release AIG Australia Limited from any further liability in relation to this payment.
- AIG Australia Limited is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to AIG Australia Limited collecting, holding and maintaining my personal information to authorise paymentsto my nominated bank account. I agree to AIG Australia Limited disclosure of this information, to my bank for the purpose and administration of processing my payment.
- I understand that my failure to supply full details and to sign this declaration may result in my payment not beingpaid or my payment being paid into a wrong account.

Signature: _____ Date: _____

Name (Print): _____

## Section 9: Loss of Income Declaration

**The following section must be completed by your employer/salary officer. If self-employed, please have your accountant complete these details.**

Name of employer: _____

Address:_____Postcode: _____

Phone: _____Fax: _____

Date ceased work due to injury: _____ Date expected to resume normal duties:_____

Employee weekly salary as at date of injury: Average Gross Base Salary $ _____ Per Week

Base salary, excluding overtime, allowances, bonuses & commissions 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: (Please Tick) 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_____From:_____To:_____

If other, please specify: _____

_____

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:_____

Company Stamp: (in space provided)_____

Phone:_____

Email:_____

ABN/ACN:_____

Salary Officers Signature: _____ Date:_____

### A- If Self Employed

Salary Officers Name: _____

Company Stamp: _____

## Section 10: Attending Physician Statement

**Important:**

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon
   (A physiotherapist may complete if claiming 5 visits or less under Additional Benefit Section 2: Physiotherapy benefit).
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: _____ Date of Birth: _____

Are you the patient's General Practitioner? _____ Yes/No _____

If not, name of usual medical doctor: _____

How long have you known the patient? _____

What date were you first consulted by the patient in connection with the present injury? _____

On what date did the patient first seek medical treatment for the present injury: _____

Name of first treatment provider for present injury: _____ Yes/No _____

What is the exact nature of the present injury? (Please detail symptoms and diagnosis and how injury was sustained)

_____

_____

Has the patient ever suffered this or a similar condition before? _____ 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:

Type: Physiotherapy ☐ Chiropractic ☐ Other (Details) ☐ _____

Number of treatments: Physiotherapy ☐ Chiropractic ☐ Other (Details) ☐ _____

Have any Surgical Procedures been performed? _____ Yes/No _____

If yes, please specify: _____

Have any Surgical Procedures been contemplated? _____ Yes/No _____

Any further remarks which may assist in assessing this condition: _____

_____

Is there a 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 _____

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: _____

## Section 10: Certification by Attending Physician

Name: _____ Qualifications: _____

Email: _____

Phone: _____ Fax: _____

Address: _____ Postcode: _____

Signature: _____ Date: _____