



How to Claim

To ensure your claim is processed quickly and efficiently please follow steps below.

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 Complete all sections of the *Sports Injury Claim Form*, excluding Sections 9 and 10.
- 3 Have your attending doctor complete the *Medical Statement* including period of your incapacity.
- 4 Complete all sections of the *Injury Data Collection* questionnaire and any applicable *Addendum to Injury Data Collection* questionnaires.
- 5 Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
- 6 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.
- 7 If you have already incurred non-Medicare medical expenses, please attach the treatment fees along with a receipt confirming the account has been paid.
- 8 When you are satisfied everything is completed correctly, please sign and date the *Sports Injury Claim Form* on the bottom of page two.
- 9 Have your appointed club official fully complete 'The Club's Declaration', Section 10.

Loss of Income Claim

- 1 Complete all sections of the *Sports Injury Claim Form*, excluding Sections 9 and 10.
- 2 Have your employer complete 'The Member's Employment Details', Section 9.
- 3 Complete all sections of the *Injury Data Collection* questionnaire and any applicable *Addendum To Injury Data Collection* questionnaires.
- 4 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.
- 5 If you are a casual employee please forward a copy of your latest tax assessment and your latest two payslips, prior to your injury
- 6 Have your attending doctor complete the *Medical Statement* including period of your incapacity.
- 7 If your incapacity continues you are required to provide a doctors certificate every four weeks.
- 8 When you are satisfied everything is completed correctly, please sign and date the *Sports Injury Claim Form* on the bottom of page two.
- 9 Have your appointed club official fully complete 'The Club's Declaration', Section 10.

Important

- 1 Your claim cannot be processed if the claim forms are incomplete. 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.

Sports

Claim Form

- Adelaide**
PO Box 10016, Adelaide BC, 5000
Phone 08 8172 8008 Fax 08 8172 8100
- Brisbane**
GPO Box 1113, Brisbane, Qld, 4001
Phone 07 3367 5160 Fax 07 3367 5120
- Hobart**
GPO Box 1454, Hobart, Tas, 7001
Phone 03 6223 8978 Fax 03 6235 1221
- Melbourne**
GPO Box 1796Q Melbourne, Vic, 3001
Phone 03 9473 6363 Fax 03 9412 2470
- Perth**
PO Box 222, Victoria Park, WA 6979
Phone 08 6250 8383 Fax 08 6250 8400
- Sydney**
PO Box 2481, North Parramatta, NSW, 1750
Phone 02 8838 5704 Fax 02 8838 5701
Website www.oampslaser.com.au



1. Please complete **Parts 1, 2, 3, 4, 5, 6, 7 and 8** of this claim form.
2. Ask **Your** doctor to complete a 'Medical Statement'
3. If **Your** claim is for loss of earnings:
 - (a) Ask **Your** employer to complete **Part 9**. 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**.
5. Attach all relevant accounts. If **You** have not yet received the accounts forward this form without them. The accounts will then need to be forwarded when **You** receive them. We will not pay any account until we receive the documentation. We need a letter of referral from a registered medical doctor for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist.

1 The Association

Sport played	➔	<input style="width: 95%;" type="text"/>
Regional Body	➔	<input style="width: 95%;" type="text"/>
Association name	➔	<input style="width: 95%;" type="text"/>
Club	➔	<input style="width: 95%;" type="text"/>
Team	➔	<input style="width: 95%;" type="text"/>
Age group	➔	<input style="width: 95%;" type="text"/>

2 The Member

Name	➔	<input style="width: 95%;" type="text"/>
Address	➔	<input style="width: 95%;" type="text"/>
Phone	➔	Work: <input style="width: 15%;" type="text"/> Home: <input style="width: 15%;" type="text"/>
Email Address	➔	<input style="width: 95%;" type="text"/>
Occupation	➔	<input style="width: 95%;" type="text"/>
Date of Birth	➔	____/____/____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Registration number	➔	<input style="width: 95%;" type="text"/>

3 Details of the Member's Disability or Injury

What is the nature of Your injury?	➔	<input style="width: 95%;" type="text"/>
What body part/s has been injured?	➔	<input style="width: 95%;" type="text"/>
Is it a recurrence of a previous injury?	➔	Yes <input type="checkbox"/> No <input type="checkbox"/>
How did it happen?	➔	<input style="width: 95%;" type="text"/>
Where were You when it happened?	➔	<input style="width: 95%;" type="text"/>
Type of location	➔	Sportsground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming pool <input type="checkbox"/>
if 'Other' <input checked="" type="checkbox"/> please describe	➔	Other <input type="checkbox"/> <input style="width: 95%;" type="text"/>
When did the injury occur?	➔	Date: ____/____/____ Time: <input style="width: 15%;" type="text"/>
What were You doing?	➔	Playing a match <input type="checkbox"/> Warm up <input type="checkbox"/> Training <input type="checkbox"/>
		Other sport <input type="checkbox"/> Gradual onset <input type="checkbox"/>

Please fold along dotted lines for mailing

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 number 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' , please 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 →

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 Ancillary cover only Hospital plus ancillary benefits

Please give details →

Name of health fund →

Do **You** have any other insurance to cover this disability or injury? →

Yes No

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

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 →

Must be completed by the injured **Member**

- 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 Brookers 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 Brookers 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.

Signature →

Date →

____/____/____

The Member's Employment Details

9

Employer's name → _____

Employer's address → _____

Phone number → _____

Date when **Your** employee ceased work → ____/____/____

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? → \$ _____

For what period have **You** paid **Your** employee sick leave? → From ____/____/____ to ____/____/____

How much sick pay have **You** paid **Your** employee? → \$ _____

What is the name of **Your** pay clerk? → _____

What is **Your** pay clerk's phone number? → _____

Signature → _____

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 attach 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
Date

at
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 → _____

Phone number → _____

Injury Data Collection

OAMPS Laser Insurance is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. OAMPS Laser Insurance, 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 <input type="checkbox"/> Coach <input type="checkbox"/> Umpire/Referee <input type="checkbox"/> Other Official <input type="checkbox"/> Voluntary Worker <input type="checkbox"/> Spectator <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
How Far Into The Activity Where You At The Time Of The Injury? ➔	Warm Up <input type="checkbox"/> 1st Quarter <input type="checkbox"/> 2nd Quarter <input type="checkbox"/> 3rd Quarter <input type="checkbox"/> 4th Quarter <input type="checkbox"/> Cool Down <input type="checkbox"/>
(Note: Your answer relates to the time into the activity, rather than the period/stage of the game)	
On What Surface Were You Participating? ➔	Grass <input type="checkbox"/> Synthetic Surface <input type="checkbox"/> Wooden Floor <input type="checkbox"/> Concrete/Bitumen <input type="checkbox"/> Gravel <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
What was The Condition Of The Surface? ➔	Normal <input type="checkbox"/> Hard <input type="checkbox"/> Wet <input type="checkbox"/> Muddy <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
What Were The Weather Conditions At The Time Of Injury? ➔	Fine <input type="checkbox"/> Light Rain <input type="checkbox"/> Heavy Rain <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
What Were The Temperature Conditions At The Time Of Injury? ➔	Very Hot <input type="checkbox"/> Hot <input type="checkbox"/> Hot & Humid <input type="checkbox"/> Mild <input type="checkbox"/> Cold <input type="checkbox"/> Very Cold <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
How Was The Onset Of Injury? ➔	Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Started Play With Pre-Existing Injury <input type="checkbox"/>
If A Collision Injury, What Did You Collide With? ➔	Ground <input type="checkbox"/> Equipment <input type="checkbox"/> Player <input type="checkbox"/> Other Structure <input type="checkbox"/>
If Other Structure, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
What Was Your Activity Leading To The Injury? ➔	Landing <input type="checkbox"/> Jumping <input type="checkbox"/> Twist/Turn <input type="checkbox"/> Side Stepping <input type="checkbox"/> Starting <input type="checkbox"/> Stopping <input type="checkbox"/> Running <input type="checkbox"/> Applying Tackle <input type="checkbox"/> Being Tackled <input type="checkbox"/> Receiving Ball <input type="checkbox"/> Passing/Throwing <input type="checkbox"/> Hitting <input type="checkbox"/> Kicking <input type="checkbox"/> Scrum <input type="checkbox"/> Ruck <input type="checkbox"/> Maul <input type="checkbox"/> Other <input type="checkbox"/>
If Other, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
Was Protective Equipment, Tape or Support Being Worn On The Injury Site? ➔	No <input type="checkbox"/> Yes <input type="checkbox"/>
If Yes, Please Provide Details ➔	Taping <input type="checkbox"/> Protective Equip. <input type="checkbox"/> Other Support <input type="checkbox"/>
If Protective Equipment, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
If Other Support, Please Provide Details ➔	<input style="width: 100%; height: 20px;" type="text"/>
How Did The Injury Severity Affect Your Playing? ➔	Unable To Continue Playing <input type="checkbox"/> Continued To Play After Treatment <input type="checkbox"/> Continued To Play Without Treatment <input type="checkbox"/>

What Was The Immediate Treatment? (more than one box may be ticked)

- | | | | | | |
|-----------|--------------------------|------------|--------------------------|--------------|--------------------------|
| Rest | <input type="checkbox"/> | Ice | <input type="checkbox"/> | Compression | <input type="checkbox"/> |
| Elevation | <input type="checkbox"/> | Stretching | <input type="checkbox"/> | Mobilisation | <input type="checkbox"/> |
| Taping | <input type="checkbox"/> | Bandaging | <input type="checkbox"/> | Sling | <input type="checkbox"/> |
| Splint | <input type="checkbox"/> | Other | <input type="checkbox"/> | Unknown | <input type="checkbox"/> |

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

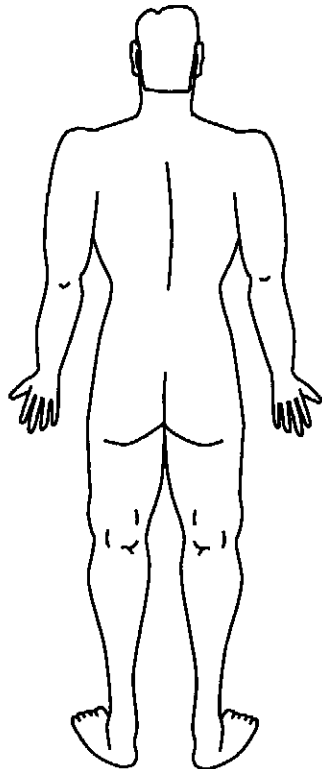
If Immediate Off Site Treatment Was Necessary,
What Mode Of Transport Was Used?

- Ambulance
Private Vehicle
Other

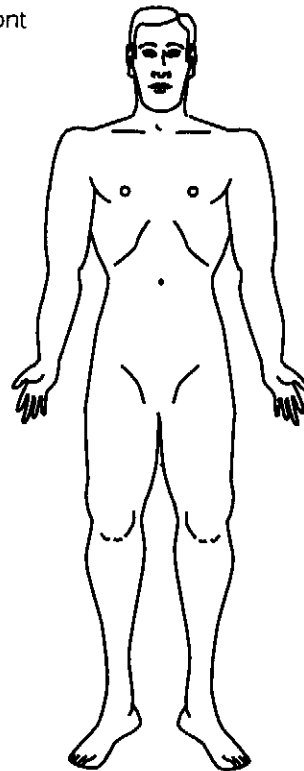
If Other, Please Provide details

Please Indicate The Site Of Your Injury On
The Appropriate Diagram Below

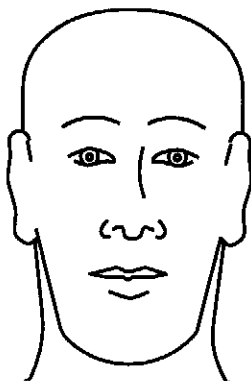
Back



Front



Head



Adelaide
PO Box 10016, Adelaide BC, 5000
Phone 08 8172 8008 Fax 08 8172 8100

Brisbane
GPO Box 1113, Brisbane, Qld, 4001
Phone 07 3367 5160 Fax 07 3367 5120

Hobart
GPO Box 1454, Hobart, Tas, 7001
Phone 03 6223 8978 Fax 03 6235 1221

Melbourne
GPO Box 1796Q Melbourne, Vic, 3001
Phone 03 9473 6363 Fax 03 9412 2470

Perth
PO Box 222, Victoria Park, WA 6979
Phone 08 6250 8383 Fax 08 6250 8400

Sydney
PO Box 2481, North Parramatta, NSW, 1750
Phone 02 8838 5704 Fax 02 8838 5701
Website www.oampslaser.com.au



Medical Statement

The Association & Club

Association name

Club name

Type of Sport

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

The Member

Name

Address

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 a 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?

Yes No

If 'No' , from what date

Regular work . / . / . Light duties . / . / .

When will the patient be able to resume for

Regular work . / . / . Light duties . / . / .

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Group Sport Personal Accident

Insured Persons: All players, coaches, umpires/referees, officials, first aid personnel, administrators and voluntary workers.

Scope of Cover: Cover limited to injury whilst an insured person is:

- Playing in club and representatives games, competitions and performances
- Participating in training or practice sessions, or official functions arranged by the insured
- Travelling to or from club and representative games, competitions or performances, training or practice sessions, meetings or official functions arranged by the insured
- Engaged in activities connected with the sport whilst staying away from home during a tour for the purpose of participating
- Whilst an Insured Person is engaged in voluntary work/committee meetings authorised by and under the control of the insured.

Age Limits: No age limits apply

Policy Benefits:

Benefits	Seniors Including Loss of Income Silver	Juniors Excluding Loss of Income Bronze
Capital Benefits	\$50,000	\$50,000
Modification Expenses	\$10,000	\$10,000
Funeral Expenses	\$5,000	\$5,000
In Memoriam Benefit	\$1,000	\$1,000
Loss of Earnings: - Weekly Benefit - % Covered - Excess - Benefit Period	\$350 100% 7 days 52 weeks	-
Student Help: - Weekly Benefit - % Covered - Excess - Benefit Period	\$350 100% 7 days 52 weeks	-
Home Help: - Weekly Benefit - % Covered - Excess - Benefit Period	\$350 100% 7 days 52 weeks	-

Benefits	Seniors Including Loss of Income Silver	Juniors Excluding Loss of Income Bronze
Parents Allowance: - Daily Benefit - Maximum Benefit	\$25 \$1,500	\$25 \$1,500
Dependent Children's Allowance	\$500	\$500
Medical and Dental Costs: - Maximum Benefit - % Covered - Excess - With Private Health - No Private Health	\$2,000 85% \$0 \$50	\$1,500 85% \$0 \$50
Home Nursing Care: - Weekly Benefit - Excess - Benefit Period	\$300 7 days 52 weeks	\$300 7 days 52 weeks
Ancillary Non Medical Expenses	\$1,500	\$1,500
Rehabilitation Benefits – Tuition	\$3,000	\$3,000
Rehabilitation Benefits – Gym membership	\$500	\$500
Unexpired Membership Reimbursement	\$500	\$500
Miscarriage and Premature Childbirth	\$2,500	\$2,500
HIV	\$5,000	\$5,000
Kidnapping	\$5,000	\$5,000