

Form

  
**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

<b>1</b>	Sport played			
	Regional body			
	Association name			
	Club			
	Team			
	Age group			
	Grade	<input type="checkbox"/>	Seniors <input type="checkbox"/>	Reserves <input type="checkbox"/> (if applicable)

## The Member

<b>2</b>	Name			
	Address			
			P/code	
	Phone	Work <input type="checkbox"/>	Mobile <input type="checkbox"/>	
	Email Address			
	Occupation			
	Date of Birth	..... / ..... / .....	Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>
	Registration number			

## Details of the Member's Disability or Injury

<b>3</b>	What is the nature of <b>Your</b> injury?			
	What body part/s has been injured?			
	Is it a recurrence of a previous injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	How did it happen?			
	Where were <b>You</b> when it happened?			
	Type of location	Sportsground <input type="checkbox"/>	Gymnasium <input type="checkbox"/>	Swimming pool <input type="checkbox"/>
		Other <input type="checkbox"/>		
	If 'Other' please describe			
When did the injury occur?	Date: ..... / ..... / .....	Time:		
What were <b>You</b> 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"/>		
What was the event?	Competition <input type="checkbox"/>	Regular training <input type="checkbox"/>	Training camp <input type="checkbox"/>	
	Private training <input type="checkbox"/>	Other <input type="checkbox"/>		
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  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? 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

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

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.

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)

\$ 

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 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? \$ 

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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	..... <small style="text-align: center;">Secretary or Treasurer</small>	
of	..... <small style="text-align: center;">Name of club and association</small>	
Confirm that	..... <small style="text-align: center;">Member's name</small>	
Sustained the injuries resulting in this claim on	.....	
	..... at ..... <small style="text-align: center;">Date time</small>	
While playing or training for	..... <small style="text-align: center;">Team</small>	
against	..... <small style="text-align: center;">Opposition Team</small>	
or while taking part in	..... <small style="text-align: center;">Activity</small>	
against	..... <small style="text-align: center;">Opposition Team</small>	
at	..... <small style="text-align: center;">Place of game or activity</small>	
The first consultation with a doctor for this injury was on	.....	
	..... <small style="text-align: center;">Date</small>	
at	..... <small style="text-align: center;">Address of doctor</small>	
Signature	<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="height: 40px;"></td></tr></table>	

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

Club mailing address 

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	P/code	
--	--------	--

Phone number 

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## 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?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Participant <input type="checkbox"/></td> <td style="width: 33%;">Coach <input type="checkbox"/></td> <td style="width: 33%;">Umpire/Referee <input type="checkbox"/></td> </tr> <tr> <td>Other Official <input type="checkbox"/></td> <td>Voluntary Worker <input type="checkbox"/></td> <td>Spectator <input type="checkbox"/></td> </tr> <tr> <td>Other <input type="checkbox"/></td> <td colspan="2"></td> </tr> </table>	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"/>											
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Other <input type="checkbox"/>																			
	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)	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Warm up <input type="checkbox"/></td> <td style="width: 33%;">2nd Quarter <input type="checkbox"/></td> <td style="width: 33%;"></td> </tr> <tr> <td>1st Quarter <input type="checkbox"/></td> <td>4th Quarter <input type="checkbox"/></td> <td></td> </tr> <tr> <td>3rd Quarter <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Cool Down <input type="checkbox"/></td> <td></td> <td></td> </tr> </table>	Warm up <input type="checkbox"/>	2nd Quarter <input type="checkbox"/>		1st Quarter <input type="checkbox"/>	4th Quarter <input type="checkbox"/>		3rd Quarter <input type="checkbox"/>			Cool Down <input type="checkbox"/>								
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Cool Down <input type="checkbox"/>																			
On what surface were You participating?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Grass <input type="checkbox"/></td> <td style="width: 33%;">Synthetic Surface <input type="checkbox"/></td> <td style="width: 33%;">Wooden Floor <input type="checkbox"/></td> </tr> <tr> <td>Gravel <input type="checkbox"/></td> <td>Concrete/Bitumen <input type="checkbox"/></td> <td>Other <input type="checkbox"/></td> </tr> </table>	Grass <input type="checkbox"/>	Synthetic Surface <input type="checkbox"/>	Wooden Floor <input type="checkbox"/>	Gravel <input type="checkbox"/>	Concrete/Bitumen <input type="checkbox"/>	Other <input type="checkbox"/>												
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	If 'Other', please provide details																		
What was the condition of the surface?	<table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Normal <input type="checkbox"/></td> <td style="width: 25%;">Hard <input type="checkbox"/></td> <td style="width: 25%;">Wet <input type="checkbox"/></td> <td style="width: 25%;">Muddy <input type="checkbox"/></td> </tr> <tr> <td>Other <input type="checkbox"/></td> <td colspan="3"></td> </tr> </table>	Normal <input type="checkbox"/>	Hard <input type="checkbox"/>	Wet <input type="checkbox"/>	Muddy <input type="checkbox"/>	Other <input type="checkbox"/>													
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Other <input type="checkbox"/>																			
	If 'Other', please provide details																		
What were the weather conditions as the time of injury?	<table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Fine <input type="checkbox"/></td> <td style="width: 25%;">Light Rain <input type="checkbox"/></td> <td style="width: 25%;">Heavy Rain <input type="checkbox"/></td> <td style="width: 25%;">Other <input type="checkbox"/></td> </tr> </table>	Fine <input type="checkbox"/>	Light Rain <input type="checkbox"/>	Heavy Rain <input type="checkbox"/>	Other <input type="checkbox"/>														
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	If 'Other', please provide details																		
What were the temperature conditions as the time of injury?	<table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Very Hot <input type="checkbox"/></td> <td style="width: 25%;">Hot <input type="checkbox"/></td> <td style="width: 25%;">Hot &amp; Humid <input type="checkbox"/></td> <td style="width: 25%;">Mild <input type="checkbox"/></td> </tr> <tr> <td>Cold <input type="checkbox"/></td> <td>Very Cold <input type="checkbox"/></td> <td>Other <input type="checkbox"/></td> <td></td> </tr> </table>	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"/>											
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Cold <input type="checkbox"/>	Very Cold <input type="checkbox"/>	Other <input type="checkbox"/>																	
	If 'Other', please provide details																		
How was the onset of injury?	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Sudden <input type="checkbox"/></td> <td style="width: 50%;">Gradual <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Started Play With Pre-Existing Injury <input type="checkbox"/></td> </tr> </table>	Sudden <input type="checkbox"/>	Gradual <input type="checkbox"/>	Started Play With Pre-Existing Injury <input type="checkbox"/>															
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If a collision injury, what did You collide with?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Ground <input type="checkbox"/></td> <td style="width: 33%;">Equipment <input type="checkbox"/></td> <td style="width: 33%;">Player <input type="checkbox"/></td> </tr> <tr> <td>Other Structure <input type="checkbox"/></td> <td colspan="2"></td> </tr> </table>	Ground <input type="checkbox"/>	Equipment <input type="checkbox"/>	Player <input type="checkbox"/>	Other Structure <input type="checkbox"/>														
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	If 'Other', please provide details																		
What was Your activity leading to the injury?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Landing <input type="checkbox"/></td> <td style="width: 33%;">Jumping <input type="checkbox"/></td> <td style="width: 33%;">Twist/Turn <input type="checkbox"/></td> </tr> <tr> <td>Side Stepping <input type="checkbox"/></td> <td>Starting <input type="checkbox"/></td> <td>Stopping <input type="checkbox"/></td> </tr> <tr> <td>Running <input type="checkbox"/></td> <td>Applying Tackle <input type="checkbox"/></td> <td>Being Tackled <input type="checkbox"/></td> </tr> <tr> <td>Receiving Ball <input type="checkbox"/></td> <td>Passing/Throwing <input type="checkbox"/></td> <td>Hitting <input type="checkbox"/></td> </tr> <tr> <td>Kicking <input type="checkbox"/></td> <td>Scrum <input type="checkbox"/></td> <td>Ruck <input type="checkbox"/></td> </tr> <tr> <td>Maul <input type="checkbox"/></td> <td>Other <input type="checkbox"/></td> <td></td> </tr> </table>	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"/>	
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Was protective equipment, tape or support being worn on the injury site?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Yes <input type="checkbox"/></td> <td style="width: 33%;">No <input type="checkbox"/></td> <td style="width: 33%;"></td> </tr> </table>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																
Yes <input type="checkbox"/>	No <input type="checkbox"/>																		
If yes, please provide details	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Taping <input type="checkbox"/></td> <td style="width: 33%;">Protective Equip. <input type="checkbox"/></td> <td style="width: 33%;">Other Support <input type="checkbox"/></td> </tr> </table>	Taping <input type="checkbox"/>	Protective Equip. <input type="checkbox"/>	Other Support <input type="checkbox"/>															
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If protective equipment, please provide details																			
If other support, please provide details																			
How did the injury severity affect Your playing?	<table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Unable to Continue Playing <input type="checkbox"/></td> <td style="width: 30%;"></td> </tr> <tr> <td>Continued to Play After Treatment <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Continued to Play Without Treatment <input type="checkbox"/></td> <td></td> </tr> </table>	Unable to Continue Playing <input type="checkbox"/>		Continued to Play After Treatment <input type="checkbox"/>		Continued to Play Without Treatment <input type="checkbox"/>													
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Continued to Play Without Treatment <input type="checkbox"/>																			
What was the immediate treatment? (more than one box may be ticked)	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Rest <input type="checkbox"/></td> <td style="width: 33%;">Ice <input type="checkbox"/></td> <td style="width: 33%;">Compression <input type="checkbox"/></td> </tr> <tr> <td>Elevation <input type="checkbox"/></td> <td>Stretching <input type="checkbox"/></td> <td>Mobilisation <input type="checkbox"/></td> </tr> <tr> <td>Taping <input type="checkbox"/></td> <td>Bandaging <input type="checkbox"/></td> <td>Sling <input type="checkbox"/></td> </tr> <tr> <td>Splint <input type="checkbox"/></td> <td>Other <input type="checkbox"/></td> <td>Unknown <input type="checkbox"/></td> </tr> </table>	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"/>						
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	If 'Other' please provide details																		
Was a sports trainer present at the game?	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Yes <input type="checkbox"/></td> <td style="width: 33%;">No <input type="checkbox"/></td> <td style="width: 33%;">Unknown <input type="checkbox"/></td> </tr> </table>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>															
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>																	

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

Hospital	<input type="checkbox"/>	Doctor	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	Other	<input type="checkbox"/>		

If 'Other' please provide details

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If immediate off site treatment was necessary,

What mode of transport was used?

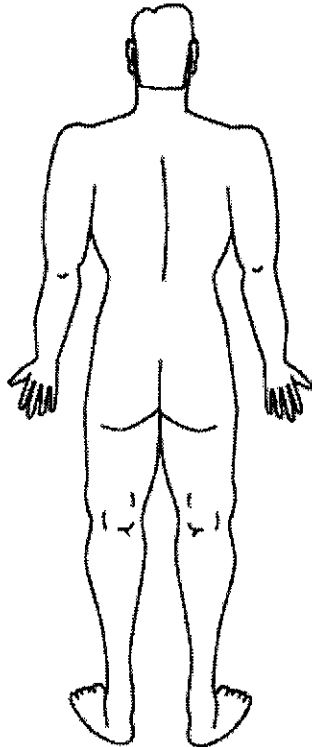
Ambulance	<input type="checkbox"/>	Private Vehicle	<input type="checkbox"/>	Other	<input type="checkbox"/>
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If 'Other', please provide details

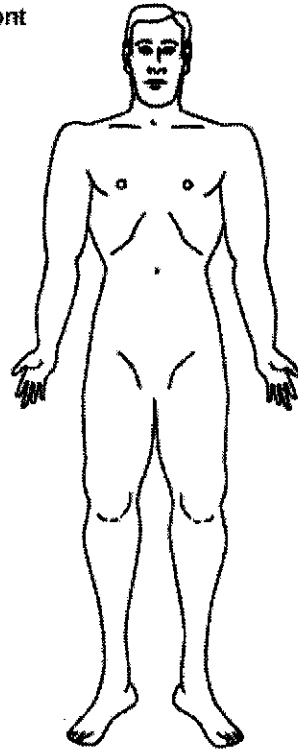
--

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

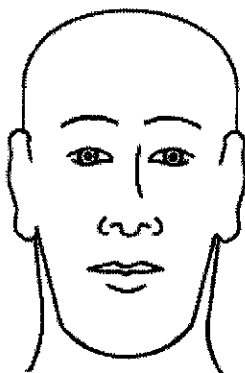
Back



Front



Head



# Medical statement

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

## The Association and Club

Association name	<input type="text"/>		
Club name	<input type="text"/>		
Type of sport	<input type="text"/>		

## The Member

Name	<input type="text"/>		
Address	<input type="text"/>		
		P/code	<input type="text"/>
Age	<input type="text"/>	Gender	<input type="text"/>

## The injury

### Complete Diagnosis

<input type="text"/>
<input type="text"/>
<input type="text"/>

### 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	<input type="checkbox"/>	Bed confined	<input type="checkbox"/>	House confined	<input type="checkbox"/>
Hospital confined	<input type="checkbox"/>	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	<input type="checkbox"/>	Performed	<input type="checkbox"/>
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### Progress

If performed Date: ..... / ..... / .....

Has condition improved? Yes  No

If 'No', please explain

<input type="text"/>
<input type="text"/>

**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 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 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](http://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

176 Wellington Parade  
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 1, 25 Grose Street  
Nth Parramatta, NSW 2151  
T: (02) 8838 5700  
F: (02) 8838 5701