

BASKETBALL PERSONAL INJURY CLAIM FORM

IMPORTANT INFORMATION: PLEASE READ CAREFULLY

Dear Basketball member,

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

1. Only one claim form (per injury) is required. A claim form should be completed and submitted within 30 days from the date of your injury occurring. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.
2. Please ensure that you fully complete Section A and sign and date the Declaration.
3. Please ensure that a Club Official completes and signs the Club Declaration in Section B.
4. For claims involving Loss of Income:-
 - a) you must arrange for your employer/salary officer to complete Section C. If self employed, you must have your accountant complete these details;
 - b) Have your General Practitioner, Surgeon, Specialist or Dentist complete the "Attending Physicians Report" and "Incapacity to Work Statement". It will **not** be accepted if completed by a Physiotherapist, Chiropractor etc.)
5. For claims involving medical expenses:-

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, surgeon, specialist or dentist).
6. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The National Health Act does not permit Insurers to contribute to any charges covered by Medicare (including the Medicare Gap).

The Insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

7. Once you have fully completed all sections of the claim form, please forward with all relating documentation and receipts to PSC Horsell Pty Ltd.

PSC Horsell Pty Ltd
PO Box N661
Grosvenor Place
SYDNEY NSW 1220

Horsell International will confirm receipt of your claim form within 5 to 10 working days. They will advise you of your claim number and where to send any ongoing medical receipts and other relating documentation.

8. If you have any further queries relating to your claim, Benefits, Excesses or Special Conditions/Exclusions, please do not hesitate to contact the Horsell International Claims Team on:-

Phone: (02) 9247 1700
Fax: (02) 9247 1733
Email: sports@horsell.com
Website: www.pscinsurancegroup.com

SECTION B. TO BE COMPLETED BY THE ASSOCIATION (NOT TO BE COMPLETED BY THE PLAYER)

ASSOCIATION DECLARATION	
I, of	
(Official)	(Name of Club)
Hereby Certify that sustained the injuries resulting in this claim on..... /...../	
(Name of Player)	(date)
At.....am/pm whilst playing/training for	
against Place of Game	
Signed:.....	Dated: /...../
(Association official)	

SECTION C. LOSS OF INCOME (IF APPLICABLE)

1. Can compensation be claimed under worker's compensation or any other insurance including Loss of income?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever made any previous claims in respect to personal accident insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you engaged in any other income earning employment since you have been injured?	<input type="checkbox"/> YES <input type="checkbox"/> NO

The following section must be completed by your employer/salary officer (not player). If self employed, please have your accountant complete these details.

NAME OF EMPLOYER				
ADDRESS OF EMPLOYER		PHONE (.....).....		
.....		FACSIMILE (.....).....		
DATE CEASED WORK DUE TO INJURY / /		DATE EXPECTED TO RESUME NORMAL DUTIES / /		
EMPLOYEE WEEKLY SALARY AS AT DATE OF INJURY NET \$..... GROSS \$..... (If Self employed, provide average weekly salary based on 12 month period directly prior to injury)		DATE COMMENCED EMPLOYMENT WITH COMPANY / /		
INCOME DEFINITION:	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Casual
During the period of incapacity has the employee received a salary? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If yes: \$..... Period..... / / to / /				
Net of business expenses, personal deductions and income tax; excludes bonuses, commissions, and other allowances; and excluding income derived from playing sport.				
A. (If employed) SALARY OFFICER'S NAME.....				
PHONE NUMBER.....				
SALARY OFFICER'S SIGNATURE.....				
DATE..... / /		COMPANY STAMP		

STATE OFFICE USE ONLY (not to be completed by player)	
I, of	
(Name)	(Company)
Hereby Certify that is a registered member of the insured state association	
(Name of Player)	
..... and I hereby sign this form in acknowledgement of the claim made.	
(Association Name)	
Signed:.....	Dated: / /

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

Surname:

Given Names:

Injury Date:

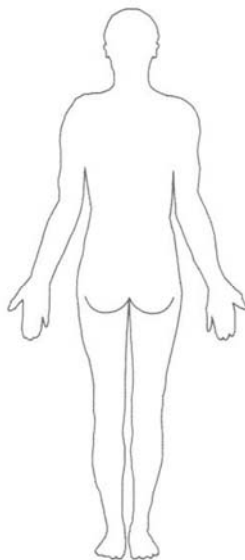
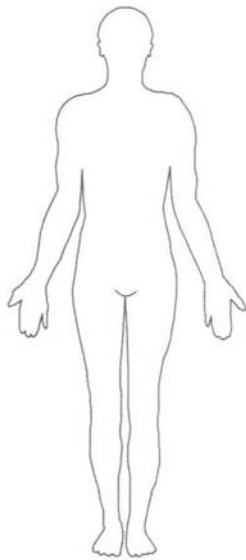
TO BE COMPLETED BY A GENERAL PRACTITIONER, SURGEON, SPECIALIST OR DENTIST

THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO PSC HORSELL

1. Diagnosis / History of Injury

.....

.....



- Concussion
 - Cut or Abrasion
 - Dislocation
 - Fracture
 - Twist
 - Sprain
 - Strain
 - Impact Contusion
 - Other
- please specify

.....

.....

.....

2. When did the patient first receive medical attention for the above?/...../.....

By Whom?

Name:

Address:

..... Postcode

3. Do you consider the Patient's injury to be a new injury? YES NO

Recurrence of an old injury? YES NO

If recurrence please give details and describe:

.....

(Continued: See Over)

4.	Does the patient have any congenital defects or chronic diseases?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	If yes, please give dates, name of treating doctor and describe:			
			
5.	Have you referred the patient to any other services or treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Please specify the approximate number of treatments required:			
	<input type="checkbox"/> Physiotherapy		
	<input type="checkbox"/> Chiropractic		
	<input type="checkbox"/> Surgery		
	please specify details).....			
			
	<input type="checkbox"/> Other		
			
			
6.	Has the patient been able to do any work since the injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
			
7.	TREATING PHYSICIAN'S NAME			
	Address			
	Postcode			
	Telephone Number: ().....Facsimile:().....			
	SIGNATURE OF TREATING PHYSICIAN:Date:...../...../.....			

*** If you have been unable to work as a result of the injury, and you are wishing to claim for Loss of Income (and your club's Policy provides this cover) please arrange for the following to be completed:-

INCAPACITY TO WORK STATEMENT

(To be completed if claiming for loss of income if continuing, a new statement must be forwarded for each period absent from employment).

CERTIFICATION BY GENERAL PRACTITIONER, SURGEON, SPECIALIST	
I examined the person named overleaf on/...../.....	
In my opinion this person is/has been unfit for work from/...../..... to/...../..... inclusive.	
Are there any further remarks or comments you can make to assist in assessing this condition?	
DOCTOR'S NAME	
Address	
Postcode.....	
Telephone Number: ().....Facsimile:().....	
DOCTOR'S SIGNATURE:.....DATED:/...../.....	