

Group Personal Accident Sports Association Claim Forms



This document consolidates all necessary claim forms required for lodging a claim.
Please note that different sections within this document will need to be completed by different parties.

1. **Sports Association Statement** pg 2

- To be completed by the relevant Sports Association.
- Please provide all required details pertaining to the incident, including any supporting documentation or information as requested.

2. **Sports Association Claim Form** pg 3-5

- To be completed by the injured/covered person.
- Please provide all relevant personal details and claim-related information.

3. **Physician's Report** pg 6-8

- To be completed by the treating registered physician.
- Please include the Injured person's medical diagnosis, treatments provided, and any relevant details regarding the claimed injury.

How to submit your claim:

1. Please make sure all 3 forms are complete in full with any attachments of additional information to ensure we can process your claim promptly.
2. Send the completed claim forms and attachments to:

Email: ah.claims@allianz.com.au

OR

Allianz Australia Insurance Limited
Attention: A & H Claims
GPO Box 4049
Sydney NSW 2001
3. For general enquiries please call us on: 1300 803 063.

Group Personal Accident Sports Association Statement

Policy number: AAH _____

Please have this certificate completed by the Sports Association representative.

Member and membership details

Name of injured member _____ Membership Number _____ Date of birth ____ / ____ / ____

On what date did membership commence with the Sports Association? ____ / ____ / ____

Was the member, listed above, registered at the time of the injury? Yes ☐ No ☐

What date and time did the injury occur? ____ / ____ / ____ Time _____

Where did the injury occur?

How did the injury occur?

Were there any witnesses to the accident (if "Yes", please provide details)

If there were no witnesses, are you satisfied the member was injured on the above date whilst participating in a club game or training session? Yes ☐ No ☐

If "No", please provide reasons

Representative's Declaration

I declare that to the best of my knowledge the information I give in this form is true, correct and complete.

Print name _____ Date ____ / ____ / ____

Position held _____

Telephone no. (____) _____ Email address _____

PLEASE NOTE: IF THIS FORM IS ELECTRONICALLY SIGNED BELOW, IT WILL BE LOCKED AND NO FURTHER CHANGES WILL BE POSSIBLE. PLEASE CHECK INFORMATION ON ALL PAGES IS CORRECT AND COMPLETE BEFORE SIGNING. IF YOU SUBSEQUENTLY DISCOVER ANY OF YOUR ANSWERS ARE INCORRECT, PLEASE CALL US ON 1300 803 063.

Your signature _____

Group Personal Accident Sports Association Claim Form

Policy number: AAH _____

Instructions

1. Please read and complete this claim form carefully. Answer all questions in full.
2. Please take this form to your registered medical practitioner to complete the Physician's Report.
3. Please sign the Privacy and Declaration section.

Your details

Full name _____ Date of birth ____ / ____ / ____

Address _____ State _____ Postcode _____

Telephone no. (____) _____ Email address _____

Preferred method of contact Email ☐ Telephone ☐ Letter ☐

Sporting Association (in full) _____

ONLY complete this section for LUMP SUM BENEFITS

Details of claimed condition for Lump sum benefits

Lump Sum Benefits ☐ Fractured Bones ☐ Non-Medicare Medical Expenses ☐

Your Payment details

Please provide details of the bank account we should use for payment of benefits approved to be paid to you.

Name of financial institution _____

Name of account holder _____

BSB number _____

Account number _____

This section must be completed

Injury Details

Was your activity at the time of the accident?

Officially organised competition ☐ Officially organised training ☐ Social or private competition ☐

Travelling to and from an organised activity ☐ Sanctioned fundraising/ social event ☐

What date and time did the injury occur? ____ / ____ / ____ Time _____

Please provide specific details of how the injury occurred that is being claimed?

Where did the injury occur?

Name of person injury was reported?

ONLY complete this section for WEEKLY BENEFITS

Details of claimed condition for Weekly Benefits

Employment Details

Name of Employer _____

Address _____ State _____ Postcode _____

Telephone no. () _____ Email address _____

Did you reduce your hours/duties as a result of the injury? Yes ☐ No ☐ If "Yes", from when? ____ / ____ / ____

Have you returned to work full-time? Yes ☐ No ☐ If "Yes", when? ____ / ____ / ____

Have you returned to part-time work or restricted/modified duties? Yes ☐ No ☐ If "Yes", when? ____ / ____ / ____

What hours and duties are you working per week? Days _____ Hours _____

Full duties ☐ Modified or restricted duties ☐ If you are working modified or restricted duties, please provide details

Please arrange for your registered medical practitioner, treating specialist or physiotherapist to complete the physician's report as well as any additional supporting evidence to support your claim at your own expense.

Treating Specialist details

When did you first obtain Specialist medical advice or treatment for this condition? ____ / ____ / ____

Please provide details of any treating specialist seen in relation to the current medical condition

Name of specialist _____

Address _____ State _____ Postcode _____

Telephone no. () _____ Email address _____

If there are additional medical practitioners, please attach a separate page with the information.

ONLY complete this section if admitted to hospital

Hospitalisation Details

Details of any hospitalisation for the conditions preventing you from working

Period of admission ____ / ____ / ____ to ____ / ____ / ____

Name of hospital _____

Address _____ State _____ Postcode _____

Reason for admission _____

If there are additional periods of hospitalisation, please attach a separate page with the information.

ONLY complete this section if you have claimed other insurance

Other Insurance claims/Private Health Insurance

Do you have Private Health Insurance? Yes ☐ No ☐

If "Yes", please provide Fund Name _____ Member Number _____

Do you have Hospital Cover? Yes ☐ No ☐

Please list any extra coverages as listed on your Private Health Insurance

Have you lodged any other claim (including pending claims) for the same injury with another insurer? Yes ☐ No ☐

Name and contact details of insurer _____ Claim Number _____

ONLY complete this section if claiming Non-Medicare Medical Expenses

Non-Medicare Medical Expenses

Do not attach accounts paid or part paid by Medicare. The Health Insurance Act 1973 (Cth) does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

For all non-Medicare costs that are claimed we will require a copy of the medical bill with itemised costs.

Non-Medicare Medical Expenses – Include but not limited to:

Dental, Chiropractic, Osteopathy, Private Hospital Bed and Theatre Fees,
Ambulance, Physiotherapy.

Medicare Medical Expenses – Include but not limited to:

Doctor Fees, Anaesthetist's Fees, Surgeons Fees,
X-ray benefits.

Name of Provider	Nature of Service (eg dental/physio)	Date of Service	Fee Charge	Private Health Fund Recovery (if applicable)	Amount Claimable
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			
		____ / ____ / ____			

In most cases Medicare does not cover 100% of the medical providers costs. The difference is known as the "Medicare Gap" and is not covered by the Allianz Personal Accident program due to government legislation.

Privacy

At Allianz, we give priority to protecting the privacy of your personal information. We do this by handling personal information in a responsible manner and in accordance with the Privacy Act 1988.

How we collect your personal information

We usually collect your personal information directly from you. We may also collect it from your agents, health service providers, other insurers, Centrelink, your employer, and other third parties involved in your claim. In some cases, we may also collect information from publicly available sources.

Why we collect your personal information

We collect your personal and sensitive information for the purposes of claims management. This information will be used to assess and process this claim, compile and analyse data, and resolve claim disputes.

If you do not provide your personal information we require we may not be able to assess or process this claim.

Who we disclose your personal information to

We may disclose your personal information to others for the purpose outlined above. This may include disclosure to third parties who assist us in assessing and processing this claim, including other insurers, reinsurers, health service providers, investigators, our specialist advisors, our service providers, dispute resolution bodies or as required by law.

Disclosure overseas

Your personal information may be disclosed to and stored by service providers that may be located overseas. The countries in which these recipients may be located will vary from time to time.

Access to and correction of your personal information and complaints

You may ask for access to the personal information we hold about you and seek correction by contacting us. Our Privacy Policy contains details about how you may make a complaint about a breach of the privacy principles contained in the Privacy Act 1988 and how we deal with complaints. Our Privacy Policy is available at www.allianz.com.au or contact us on 1300 360 529 EST 9am - 5pm, Monday - Friday.

Declaration and authority

I understand and declare that: the information given in this form is truthful, accurate and complete; no information likely to affect this claim has been withheld; I understand that this claim may be refused if information is untrue, inaccurate or omitted; and all personal information provided by me about another person is provided with their consent.

I authorise, consent to and direct all health providers, including but not limited to medical practitioners, practices, psychologists, dentists, allied health services providers or any hospitals, Medicare, my employer (and their representatives and agents), insurance brokers, the Police, the Coroner and all insurance companies to supply Allianz (or its agents) with any health information, employment, accident or insurance information which they hold, are aware of or able to obtain with regard to me.

I agree that my digital signature and a photocopy or photograph of this Authority when attached to a letter or email from Allianz (or its agents) shall be considered to be valid as if it were the original Authority personally signed by me.

Print name _____ Date ____ / ____ / ____

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Your signature _____

Group Personal Accident Sports Association Physician's report

You must arrange for your regular registered medical practitioner, treating specialist or physiotherapist to complete this certificate at your own expense.

Patient details

Name of patient _____ Date of birth ____ / ____ / ____

When did the patient first attend your practice? ____ / ____ / ____

Date patient referred ____ / ____ / ____ Name of referring doctor _____

Present condition

If you are unable to answer any of the questions below, please indicate.

Diagnosis of present condition (or description of injury if no diagnosis available)

What evidence was used to diagnose the injury _____

*** Please attach a copy of all test results relevant to the diagnosis of this condition.**

On what date did the injury occur? ____ / ____ / ____

How did the injury occur?

On what date did you first treat the patient for this condition? ____ / ____ / ____

Has your patient previously suffered from the same/similar condition or any condition that has contributed or is related to the condition? Yes ☐ No ☐

If "Yes", please provide details

Condition _____ Date of onset/resolution ____ / ____ / ____ to ____ / ____ / ____

Treatment received _____

Condition _____ Date of onset/resolution ____ / ____ / ____ to ____ / ____ / ____

Treatment received _____

Name and address of doctor who first diagnosed or treated the condition

Have you referred the patient to any other services or treatment? Yes ☐ No ☐

Please specify the type and approximate number of treatments required:

☐ Physiotherapy _____

☐ Chiropractic _____

☐ Other _____

Have any surgical procedures been performed? If "Yes", please specify:

What surgical procedures are contemplated?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability at present?

Yes ☐ No ☐

If patient has been hospitalised, please provide dates from ____ / ____ / ____ to ____ / ____ / ____

Name of hospital _____

Describe any procedure/surgery performed

Work capacity

Patient's occupation and usual duties? _____

Patient's usual working hours per week? _____

Do you consider the patient is or has been unable to attend or engage in their usual employment due to their injury?

Yes ☐ No ☐

If "Yes", from what date ____ / ____ / ____

Have they returned to their usual employment?

Yes ☐ No ☐

If "Yes", from what date ____ / ____ / ____

If the patient has not returned to work in full capacity, please provide details of the patient's employment capacity for all periods from the date they were unfit, including expected capacity into the foreseeable future.

Capacity for Work	Period From	Period To
Totally unfit for their usual occupation	____ / ____ / ____	____ / ____ / ____
Partially unfit for their usual occupation	____ / ____ / ____	____ / ____ / ____

If the patient is partially unfit, please detail the restrictions placed on hours and/or duties:

Can work _____ hours per day _____ days per week _____

Restrictions on duties

What is the expected duration of future incapacity from today's date? (tick the relevant box)

Up to 3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-18 months ☐ 18-24 months ☐ More than 24 months ☐

Do you consider the patient will never return to: usual occupational duties and hours ☐ any type of work ☐

Please explain why this is the case

Is there anything in the patient's medical history which is currently, or has contributed, to the patient's inability to work?

Yes ☐ No ☐

If "Yes", please provide details

Are there any other factors playing a role in the patient's inability to work?

Yes ☐ No ☐

If "Yes", please provide details

Current treatment

Has the patient complied with the treatment plan?

Yes ☐ No ☐

If "No", why not?

Please provide us with any other comments you may have to assist with the assessment of your patient's claim

Physician's Declaration

I hereby certify that I have personally attended to the patient and that all information provided by me on this form is accurate and complete.

Name

Qualifications

Address State Postcode

Telephone no. () Email address

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Date / / Your signature