Sports Group Personal Accident

Claim Form

RYNO INSURANCE
We go the extra mile

Motor | Liability | Accident & Sickness

Call **1300 650 670** or email **claims@rynoinsurance.com.au**
rynoinsurance.com.au

Claim Form

Dear Member,

IMPORTANT INFORMATION, relevant to YOUR Claim, is contained on this page of the Claim Form and the enclosed Policy Wording. PLEASE read them and make sure you understand their contents.

We require the claim form to be returned (fully completed) to Ryno Insurance Services within 120 days of your injury. Do not wait until treatment is complete before submitting the claim form

1. The Physician's Statement must be completed by the main Doctor, Chiropractor, Physiotherapist or Dentist who is providing treatment for your injury.
2. For Claims under the "LUMP SUM" Net Loss of Income Benefit your Employer must complete the Employer's Statement and forward it directly to Ryno Insurance Services. If you are self employed, the financial statement showing income details must be completed by your Accountant. A Return to Work Statement from your Employer is also required before processing can be completed.
3. Please send all original receipts for Non Medicare Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts.
4. Claims cannot be settled (entitlements calculated) until all treatment relating to the injury has been completed, all accounts have been paid and refunds from your Private Health Insurer have been obtained. Claims for Loss of Wages will only be processed once we have been provided with a Return to Work date.
5. In most cases, there are varying Excesses on claims for Medical Expenses and an excess of varying periods on claims for loss of earnings. For precise details and information regarding Policy maximums and excesses, please contact your Club or Association.

If you have any queries, please contact us.

Ryno Insurance Services Claims Department
Telephone: 1300 650 670
Email: claims@rynoinsurance.com.au

RYNO INSURANCE SERVICES			
BRISBANE	19 Rosedale St Coopers Plains QLD 4108	Ph: 1300 650 670	Fax: 1300 797 768

ABN: 83 010 630 092 **AFS Licence No:** 230041
Email: claims@rynoinsurance.com.au
Website: www.rynoinsurance.com.au

CLAIMS HOTLINE: 1300 650 670

Sports group Personal Accident Claim Form

All sections must be completed

Before you commence filling in this Form, please make sure you have read and fully understood the dialogue on the front of the Claim Form as it contains important information relevant to your claim. If you have any questions at all about its contents or meaning, please contact Ryno Insurance Services

Sport .....

Name of Claimant .....
Surname *Given names*

Address for Correspondence .....

..... State ..... Postcode .....

Telephone (AH) ..... (BH) ..... Fax .....

Email .....

Website .....

Team/Club ..... Association *(in full)* .....

Date of Birth ...../...../..... Sex Male ☐ Female ☐

Occupation .....

1. (a) Please give a full description of the circumstances of the accident which led to the injury

.....

.....

(b) Please provide a copy of the **teamsheet/scoresheet** where the details of the accident have been recorded

(c) When did the injury occur? Date ...../...../..... Time ...../...../..... am / pm

(d) Please provide the address of where the injury occurred? .....

..... Postcode .....

2. (a) What injuries did you receive? .....

(b) When did you first consult a practitioner for this injury? .....

(c) Is treatment complete for this injury? YES ☐ NO ☐ (If not, please notify us in writing as soon as it is)

3. Were you admitted to Hospital? YES ☐ NO ☐

If yes: Name of Hospital .....

Address ..... Postcode .....

In Patient ☐ Out Patient ☐ Name of Attending Doctor .....

4. Are you now, or have you ever been, subject to or affected by other injury or Disease, Deformity, Defect of Senses, Infirmity or Weakness?

YES ☐ NO ☐

If yes, please give details .....

.....

5. Have you ever lodged a personal accident claim before?

YES ☐ NO ☐

If yes, please give details .....

6. (a) Are you a member of a Private Health Insurance Fund? YES ☐ NO ☐

If yes, please give details Fund Name ..... Member Number .....

(b) Are you entitled to claim for any of the following benefits? YES ☐ NO ☐

Private Hospital ☐ Physiotherapy ☐ Dental ☐

Chiropractic ☐ Ambulance ☐ Massage ☐

Other ancillary procedures – please give details .....

7. Are you making or entitled to make, a claim in respect of this injury for any of the following?

Sick Leave YES ☐ NO ☐ Workers Compensation YES ☐ NO ☐

Motor Government Benefits YES ☐ NO ☐ Superannuation Life Insurance YES ☐ NO ☐

If yes, please give details .....

.....

NOTE Original receipts and all statements of any benefit received from any other source must be sent to Ryno Insurance Services. Failure to do so will result in Settlement Delays. Please remember to inform us in writing when your treatment is complete. This will reduce delays in settlement of your claim.

NOTE Once your claim has been settled, we can, if you wish, transfer the funds directly to your bank account. This will provide you with immediate access to the funds as there are no cheque clearance delays. If you wish to avail yourself of this service, please provide us with the following details of your bank account.

BANK NAME .....

BENEFICIARY NAME .....

BSB NUMBER ☐☐☐☐☐☐ Minimum 6 digits

ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐ Maximum 9 digits

DECLARATION AND AUTHORISATION BY INJURED PERSON

Name .....
Surname *Given names*

I hereby authorise any hospital, physician or other persons who have attended me, or any employer, to furnish Ryno Insurance Services or their authorised representative with any illness or injury, medical history, consultation, prescriptions or treatment, copies of hospital or medical records and copies of all records of employers.
I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Date ...../...../..... Signature .....

We require a statement from anyone who witnessed your accident.
Please have that person complete this section.

Name .....

Address .....

Telephone (AH) ..... (BH) .....

Please give a full description of the accident giving a rise to the claimant's injury, as you saw it .....

.....

.....

Date ...../...../..... Signature .....

Complete this section only if you wish to claim for LOSS OF EARNINGS

Employer's Name .....

Employer's Address .....

..... State ..... Postcode .....

1. Are you Full Time ☐
   Part Time ☐ Working ☐ Hours Per Week
   Self Employed ☐

2. What is your Occupation? .....
3. What are your net Earnings per annum? .....
4. When did you cease work as a result of your injury? .....
5. Have you returned to work? If so, when? ..... Date ...../...../.....

Official Report

These questions must be completed by an authorised office bearer of the insured club/association.
NOTE The teamsheet or injury report is a separate document.

Please ensure that all questions have been fully answered

Claimant's Name .....

Date of injury ...../...../.....

1. Name of Association ..... Club .....

   Team ..... Grade player was playing in at the time of accident .....

2. Was the player listed above registered at the time of the accident? YES ☐ NO ☐

3. Were you a witness to the accident described? If yes, please give details .....

   .....

   .....

If you were not a witness, are you satisfied the player was injured on the above date whilst participating in a club game or training session?

.....

If not, please provide details which outline your concern .....

.....

.....

DECLARATION BY AN AUTHORISED OFFICE BEARER

I certify that the particulars shown on this form are, to the best of my knowledge, true and correct and hereby authorise this claim to be paid directly to

..... (claimant)

Signed ..... Print name .....

Position .....

Address ..... Telephone .....

Details of employment

To be completed only if you intend to claim for the Lump Sum Net Loss of Income benefit

NOTE 1. A claim cannot be made unless the claimant was gainfully employed and working at least 20 hours a week at the date of injury
2. The Claimant must be continuously and totally disabled for more than the excess period noted in the Policy
3. The initial week of disablement is not covered

At the time of the accident were you:

☐ A full-time employee?

☐ Part-time employee working ..... hours/week?

☐ Self-employed on a full-time basis?

Name ..... Address .....

..... State ..... Postcode .....

Please give details of your entitlement (if any) to any of the following benefits:

	NO. OF WEEKS	WEEKLY AMOUNT	TOTAL ENTITLEMENT
Sick-pay from your employer			
Other insurance benefits including Personal Accident Policies			
Other salary, wages, income or pay of any nature whatsoever being			
		TOTAL	

What was your income from all sources in the twelve months period prior to your accident? .....

Total Annual Income from all Sources $ .....

If you are an employee

Name and address of your employer or employers during the twelve month period prior to your accident

(Please show full names and address – no abbreviations)

Current Employer ..... Contact .....

Address .....

Period of employment ..... to ..... Phone No .....

Occupation/Position .....

Former Employer ..... Contact .....

Address .....

Period of employment ..... to ..... Phone No .....

Occupation/Position .....

Please list any additional former employers on a separate list. Leave blank if not applicable

Employer's Statement

To be completed by Claimants current Employer

I ..... Manager/Accountant/Director/Partner

of ..... *Name of Firm* of ..... *Address* confirm that

..... has been employed continuously by this firm

in the position of ..... since ..../..../....

His/Her gross earnings since the above date of employment (if less than 12 months ago) or for the past 12 months up to the date of his/her injury as described on this claim form amounted to $ .....

At the ..../..../.... *Date of Injury* the claimant was entitled to ..... sick days pay

I confirm that the Claimant was not entitled to receive nor did receive any form of remuneration whatsoever from this firm, his employer in respect of his/her period of disablement commencing at the above-mentioned date of injury except as follows .....

.....

.....

Signature ..... Witness .....

Accountants Statement

Self-employed persons only

To be completed by the Claimant's Accountant

I ..... Manager/Accountant/Director/Partner

of ..... *Name of Firm* of ..... *Address* confirm that

our firm act as Accountants for ..... *The Claimant* of

..... and

that his/her gross earnings (before tax but after expenses) for the 12 months period ended ..../..../....

amounted to $ ..... Income Protection YES ☐ NO ☐

Name of Company .....

Signature ..... Witness .....

Attending Physician's Statement

To be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor

The insured is responsible for the completion of this form without expense to the company

Patient's Name .....

Patient's Address .....

What is Disabling Patient? .....

Please give a complete diagnosis of this condition .....

.....

.....

HISTORY

1. When did patient first receive medical treatment? ...../...../.....

2. Was there a previous history of this or similar condition? YES ☐ NO ☐

If yes, please state condition and advise when previous treatment was given .....

.....

.....

3. (a) How long have you known the patient? ...../...../.....

(b) Are you the regular general practitioner? YES ☐ NO ☐

If not, please advise who is .....

IF INJURY:

1. When did patient suffer injury? .....

2. What were the circumstances surrounding the injury? .....

IF SICKNESS:

1. When was sickness first contracted? .....

2. When did symptoms become evident? .....

DEGREE OF DISABILITY:

1. Patient's Occupation? .....

2. When was patient obliged to cease work? .....

3. If patient is still disabled, when approximately will the patient resume:

(a) Some duties ...../...../..... (b) Full duties ...../...../.....

4. If patient has recovered, when was the patient able to resume:

(a) Some duties ...../...../..... (b) Full duties ...../...../.....

TREATMENT OF PRESENT CONDITION

1. When were you consulted? ...../...../..... (b) Most recently ...../...../.....
2. How often has the patient consulted you? .....
3. Was patient confined to hospital? YES ☐ NO ☐

   If yes, please advise: 1. Name of hospital .....

   2. Period of Confinement From ...../...../..... to ...../...../.....

4. Was confinement in a convalescent home necessary after hospitalisation YES ☐ NO ☐

   If Yes, give details .....
5. What are the current subjective symptoms? .....
6. Please give results of any objective findings:

   1. X-Rays.....

   2. Other Tests-Please advise tests done and findings 1. .....

   2. .....
7. What surgical procedures have been performed .....

.....

8. What surgical procedures are contemplated .....

.....

Are there any underlying conditions affecting recovery from the current condition? YES ☐ NO ☐

If yes, could you advise nature of underlying conditions and how they affect disability and recovery .....

.....

Has patient any other physical or mental impairment? YES ☐ NO ☐

If yes, please describe .....

.....

Please advise names and addresses of other treating physicians .....

.....

If you have terminated treatment, please advise date ...../...../.....

What is the current prognosis? .....

.....

.....

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

.....

.....

Is there any permanent disability at present? YES ☐ NO ☐

If yes, please explain giving estimated percentage loss of function .....

Date ...../...../..... Signature ..... Degree .....

Name (please print) .....

Street Address .....

City or Town ..... State ..... Phone No .....

Email ..... Website .....

RYNO INSURANCE SERVICES			
BRISBANE	19 Rosedale St Coopers Plains QLD 4108	Ph: 1300 650 670	Fax: 1300 797 768

ABN: 83 010 630 092 **AFS Licence No:** 230041
Email: claims@rynoinsurance.com.au
Website: www.rynoinsurance.com.au

CLAIMS HOTLINE: 1300 650 670

My Claims Follow-up Sheet

This section is designed to help you and the Ryno Insurance Services Claims Department in making sure that your claim is handled quickly and efficiently for an Early Settlement.
Enquiries can be made by contacting the Claims on 1300 650 670

- [x] Eg. I have received a claim form
- [ ] Sent my Ryno Insurance Services Claim Form back within 120 days of my injury

The following requirements are to be returned within 12 calendar months from the date of the injury

- [ ] Receipts and/or statements from Private Health Insurance
- [ ] Obtained a Doctors Referral
- [ ] Notified Ryno Insurance Services in writing when all my treatment is complete

If claiming for loss of income

- [ ] Employment Declaration form completed by Employer and sent to Ryno Insurance Services within 120 days of my injury

206 Health Insurance Act 1973 SI 126

PART Vii – Miscellaneous

Prohibition of certain medical insurance 126(1)

A person shall not make a contract of insurance with another person that contains a provision purporting to make the first mentioned person liable to make

a payment in the event of the incurring by the other person of a liability to pay medical expenses in respect of the rendering in Australia of a professional service for which Medicare benefit

Penalty $1000.

(2) Where there is contract of insurance (whether made before or after the commencement of this section) under which the insurer is liable to make a payment in the event of the incurring by that person of liability to pay medical expenses in respect of the rendering in Australia of a professional service, there is an implied condition in the contract that the insurer is not liable for loss arising out of the incurring of liability to pay medical expenses in respect of the rendering in Australia of a professional service in respect of which a Medicare benefit is, or but for subsection 18(4) would be, payable.

(3) Where:

(a) the proper law of a contract of insurance would, but for a term that it should be the law of some other country or a term to the like effect, be part of the law of any part of Australia; or

(b) a contract of insurance contains a term that purports to substitute, or has the effect of substituting, provisions of the law of some other country or of a State or Territory for all or any of the provisions of this section;

this section applies to the contract notwithstanding that term.

(4) Any term of a contract of insurance (including a term that is not set out in the contract but is incorporated in the contract by another term of the contract) that purports to exclude, restrict or modify or has the effect of excluding, restricting or modifying the application in relation to that contract of all or any of the provisions of this section is void.

(5) A term of a contract shall not be taken to exclude, restrict or modify the application of a provision of this section unless the term does so expressly or is inconsistent with that provision.

(5A) This section does not apply in relation to a contract of insurance entered into by a registered organisation as insurer in so far as the contract provides for benefits in accordance with the basic table.

Privacy Policy

Ryno Insurance Services is committed to protecting the privacy of the personal information Your Provide to Us in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles.

We collect Your personal information to assess Your application for insurance, administer Your Policy and pay Your claims.

If You do not provide the information that We request, Your insurance applications may not be accepted, or We may not be able to administer Your Policy or a claim. Also, You may breach Your duty of disclosure, the consequences of which are set out in the duty of disclosure section of the PDS.

We may need to share Your information with others to decide whether to accept Your Policy, administer Your Policy and manage and pay Your claims. To allow Us to do this and to otherwise operate Our business, Your personal information may be give to and used by the following:

- The Insurer of this Policy, certain Underwriters at Lloyd's and its own employees and agents. The Insurer is located in the United Kingdom. When Your information is disclosed to the Insurer it will be protected by the Data Protection Act 1998 (UK) which contains similar protection to the Australian Privacy Principles.
- Claims adjusters, lawyers and other people appointed by Us or the Insurer, or on Our behalf or the Insurer's behalf for claims handling purposes.

By submitting Your personal information to Us, You agree to Us using and disclosing Your personal information this way. This consent to the use and disclosure of Your personal information remains valid unless You alter or revoke it by giving Us written notice.

We may also use Your information to notify You about other products or promotions from time to time. We always give You the option of electing not to receive these communications. Please let Us know if You do not wish to receive this information.

If Your details or personal information changes, You should notify Us in writing of changes so We can ensure that information We hold about You is accurate, complete and up-to-date.

For details of Our policy on access to and collection of personal information We hold and how to make a complaint regarding privacy, please download a copy of Our privacy policy from our website: **www.rynoinsurance.com.au**

Complaints regarding privacy can be made to:

The Privacy Officer
Ryno Insurance Service
Po Box 239
Coopers Plains, QLD 4108
Email: privacy@rynoinsurance.com.au

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LLOYD'S

Ryno Insurance Services, a specialist division of East West Insurance Brokers Pty Ltd ABN 83 010 630 092, Australian Financial Services Licence No. 230041 acts under a binding authority granted to it by the insurers of the Ryno Insurance Services Product, Certain Underwriters at Lloyd's. Refer to the Product Disclosure Statement or call us on 1300 650 670

Ref: RY.SPCF.LLO.V.010816

19 Rosedale Street I PO Box 239
Coopers Plains QLD 4108

Follow us on :

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