BHSI

BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Sports Injury Claim Form

Completed claim forms must be sent to: Berkshire Hathaway Specialty Insurance Company

E claimsnoticeaustralia@bhspecialty.com

Claim form

Claimant details

State Association/League:

Club name (if applicable):

Member number (if applicable):

Claimant's given name: Surname:

Name of team (age/group/grade):

Gender: ☐ Male ☐ Female ☐ Other

Full name (second person/director):

Date of birth:

Occupation:

Address:

Email:

Telephone: Work: Home: Mobile:

Please tick the category applicable: ☐ Player ☐ Official ☐ Coach ☐ Referee ☐ Other

If other please advise:

Declaration agreement and authorisation by claimant

I _____ (insert name) hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer, or its agent, such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

Signature of claimant: ..... Date: .....
(or Legal Guardian if under 18 years of age)

Declaration by Club Team Manager/Official

State Association/League:

Club Name: Name of Team Manager/official making this statement:

Official Position: Telephone: Email:

Address: State: Postcode:

I, the above mentioned Team Manager/Official, confirm that the claimant was a registered and Financial member of this Club and was an insured person as identified in the Personal Accident Insurance with Berkshire Hathaway Specialty Insurance at the time of the accident, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ☐ Yes ☐ No

If yes, please detail below:

Date: Signature of Team Manager/Official:

Accident details

Describe the accident and how it happened?

Describe your injury?

When did your accident occur?

Date: Time: am ☐ pm ☐

Was your activity at the time of the accident? (please tick)

- ☐ Officially organised Competition
- ☐ Officially organised training
- ☐ Social or private competition
- ☐ Travelling to and from activity
- ☐ Sanctioned fundraising/social event

Please provide the address of where the injury occurred?

State the name of any one witness to the injury:

Contact details of witness:

Person to whom accident/incident was reported?

Date and time reported?

Date: Time: am ☐ pm ☐

Brief summary of treatment/action taken at the time of the accident/incident?

Was hospitalisation required? Yes ☐ No ☐

If yes, please advise the name of hospital?

If admitted into hospital, how long were you there?

Name of person who gave treatment?

Do you have Private Health Insurance? Yes ☐ No ☐

If yes, please give fund name?

Advise when you did (or expect to):

- Cease work/normal activities
- Cease training
- Cease participating
- Resume work/normal activities
- Resume training
- Resume participating

Have you ever had this injury or similar injuries in the past? ☐ Yes ☐ No If yes, please advise when?

The following information is required for Rugby League's research to assist with risk management.
Answering these questions will not affect your claim.

Where did your injury occur?

Surface at point of injury? (please tick)	☐ Synthetic ☐ Natural Turf ☐ Other, please advise .....
Weather conditions? (please tick)	☐ Fine ☐ Rain ☐ Showers ☐ Extreme heat ☐ Extreme cold
Surface conditions? (please tick)	☐ Wet ☐ Dry ☐ Other, please advise .....
Half injured? (please tick)	☐ 1st Half ☐ 2nd Half

Weekly Benefits

Only complete this section if claiming for these expenses

Are you entitled to sick leave? ☐ Yes ☐ No

Period you have received sick leave from and to

Are you self-employed? ☐ Yes ☐ No

If yes, confirmation of earnings must be submitted with your claim form (income tax return, profit & loss statement etc.)

If you are employed as a wage earner the section below must be completed by your employer

Name of Employer:

Employer Address:

This is to certify that _____ has been unable to attend his/her occupation as a result of injury from: to:

His/Her average gross weekly salary at the time of this accident was: $ per week

His/Her sick leave entitlement at the time of the accident was: days

He/She has been employed since:

And is expected to/did resume duties on:

Name of Supervisor or Payroll completing this form:

Telephone Number:

Email Address:

Date: Signature of Supervisor or Payroll:

Non-Medicare medical expenses

Only complete this section if claiming for these 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).

Are you a member of an Ambulance Service? ☐ Yes ☐ No

Are you a member of a Private Health Fund? ☐ Yes ☐ No

If yes, please provide details:

Hospital cover? ☐ Yes ☐ No

Extras covering (dental/physio etc.)? ☐ Yes ☐ No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

Name of provider	Nature of service eg: dental/physio	Date of service	Charge	Private Health Fund recovery (if applicable)	Amount claimable
				Total	
				Less excess	
				Total amount of claim	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of doctor: .....

Address: .....

Sports injury attending physician's report

Important

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating medical practitioner, surgeon or physiotherapist.
3. If "Yes" answered to any of the following, please give details.
4. Dashes or blank spaces are not acceptable.

To be completed by the attending physician/physiotherapist

Patient's full name:

How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?

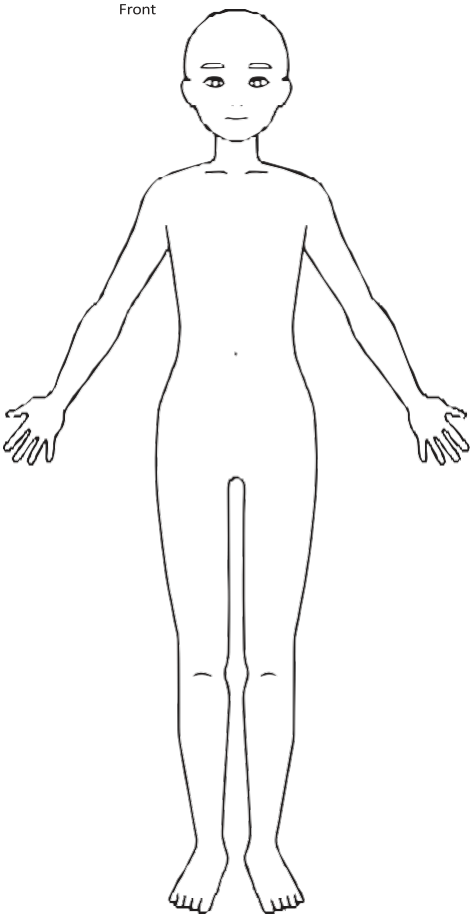
Patient's occupation:

Are you the patient's regular general practitioner? ☐ Yes ☐ No

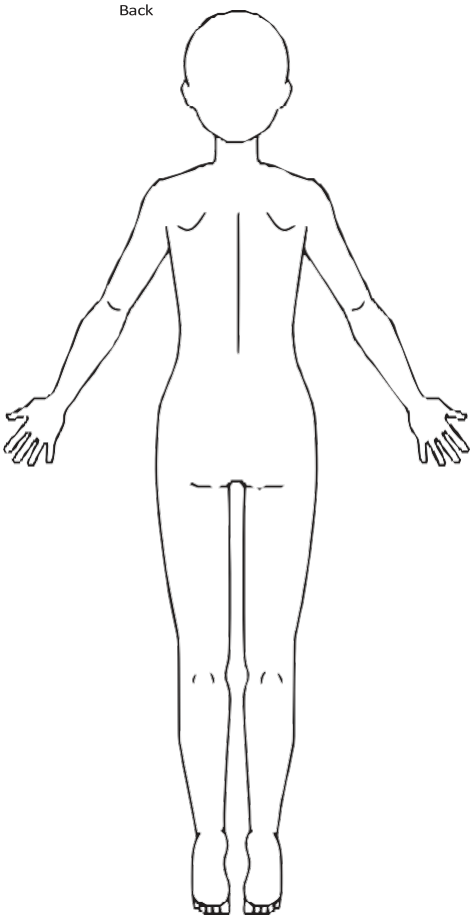
If not, please advise who is:

What is the exact nature of the present injury?

Front



Back



Do you consider the patient's injury to be a new injury? ☐ Yes ☐ No

A recurrence of an old injury? ☐ Yes ☐ No

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

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 yes, please explain giving estimated percentage loss of function:

Was the patient obliged to cease work? ☐ Yes ☐ No

If so, from when (date): .....

When do you expect the claimant to resume some duties (date): ..... full duties (date): .....

What date do you advise the patient to return to rugby league? (date): .....

Does the patient have any congenital defects or chronic diseases? ☐ Yes ☐ No

If yes, please give dates, name of treating doctor and describe:

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of hospital: ..... Date admitted ..... Date released .....

Certification by attending physician

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident Details section of this claim form are consistent with the patient's injury.

Name: Telephone:

Fax: Email:

Address:

Signature: Qualifications:

Date:

Method of payment - Electronic Funds Transfer (EFT)

Following approval of your claim, should you wish to have any benefits payable transferred directly into your bank account, please provide the following details:

Name of Financial Institution:

Account Name:

BSB: Account Number:

Bank Swift Code (International Payments):

Bank Account Currency (International Payments):

Bank Address (International Payments):

Please note that we are not liable for any bank processing fees incurred by you.

Declaration by claimant (or guardian if claimant under 18)

I hereby declare that the foregoing statements are true and correct:

Name:

Signature: Date:

Privacy and Complaints Notices

The Insurer

This insurance cover is underwritten by Berkshire Hathaway Specialty Insurance Company (inc. in Nebraska, USA. Liability is limited) ABN 84 600 643 034 AFSL 466713 (BHSI).

Privacy

BHSI, along with all companies in the Berkshire Hathaway group of insurance companies, are committed to safeguarding your privacy and the confidentiality of your personal information. BHSI, and entities acting on its behalf, only collect personal information from or about you for the purpose of assessing your application for insurance and administering your insurance policy, including managing and administering any claim made by you. Without your personal information, BHSI may not be able to issue insurance cover, administer your insurance or process your claim. BHSI will only use your personal information in accordance with the Privacy Act 1988 (Cth) and for the purposes outlined above.

BHSI may disclose your personal information to other companies in the Berkshire Hathaway group and other third-party service providers for the purposes outlined above or where disclosure is permitted by law. These entities may be located in Australia or overseas, including in New Zealand, India, Malaysia, Singapore, Hong Kong, France, Germany, the United Kingdom, Canada and the United States of America. Where such disclosure is made, BHSI make all reasonable efforts to ensure that the arrangements it has in place with overseas parties impose appropriate privacy and confidentiality obligations on those parties to ensure that imparted personal information is kept secure and that such information is only used for the purposes noted above.

If you wish to obtain details of the personal information BHSI holds about you (including contacting us to correct or update the personal information BHSI holds about you), or if you have a complaint about a breach of your privacy, please refer to BHSI's privacy policy available at https://www.bhspecialty.com/privacy-policy.html, or contact BHSI Privacy Officer by email to australasia.privacy.compliance@bhspecialty.com.

BHSI reserve the right to refuse access under the grounds permitted by the Privacy Act 1988 (Cth) and if you are seeking information on another person's behalf, BHSI will require written authorisation from that individual.

Complaints

If you have a complaint or concern about BHSI's insurance products or services it provides, BHSI would like the opportunity to resolve this with you. Please contact your intermediary or your BHSI contact or alternatively you may direct your complaint to BHSI directly by:

Email: Complaints.Australia@bhspecialty.com

Post: Berkshire Hathaway Specialty Insurance GPO Box 650, Sydney NSW 2001

BHSI will attempt to resolve the matter in accordance with the BHSI Complaints Review Process.

For more information on how BHSI handles complaints, or to obtain a copy of the BHSI Complaints Review Process, go to https://www.bhspecialty.com/aus/aus-disclosures/ or contact us.