

JLT Sport Personal Injury Claim Form

Australian Cricket National Club Risk Protection Programme



Important Information

Who should use this claim form?

You should complete this form if:

- ☒ **Insured** - You are a player, umpire, official or volunteer (Insured Person) of an Association/Club (the Insured) covered within the Australian Cricket National Club Risk Protection Programme; and
- ☒ **Injured** - You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned cricket event/activity; and
- ☒ **Non-Medicare** - You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on JLT Sport's web site www.jltsport.com.au/cricketaustralia.

What is covered?

The Australian Cricket National Club Risk Protection Programme's Personal Accident cover provides some reimbursement for Non-Medicare Medical Costs and/or Loss of Income cover for 12 months from the date of injury.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Gap. Non-Medicare Medical Benefits are covered up to the limits outlined below.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS).

How much can I claim?

The following table outlines the reimbursement capacity within the Australian Cricket National Club Risk Protection Programme.

Non-Medicare Medical Costs	Loss of Income
85% Reimbursement	85% Reimbursement
\$5,000 maximum per claim	\$500 maximum per week
\$50 excess per claim	14 day elimination period

All clubs receive the above coverage at the commencement of each period of cover. Associations/Clubs may choose to upgrade the Loss of Income cover for an additional premium. Upgraded cover is valid only from the date of purchase.

What is NOT covered?

The following examples demonstrate some areas not covered by the Personal Accident cover:

- ☒ Medicare items (see below);
- ☒ the Medicare Gap (see below);
- ☒ Injuries sustained whilst playing against medical advice.

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS) for further details.

What does "Non-Medicare" mean?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the "Medicare Gap".

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer or the JLT Trustee to reimburse any part of a Medicare Item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Australian Cricket National Club Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or www.medicare.gov.au

Please note: Some Private Health Funds may offer Medicare Gap Insurance Cover. JLT Sport is not a Private Health Fund, nor do we offer Private Health Insurance.

Important Information

Claim Conditions

Section A:
Claimant's Details

Section B:
Club Declaration

Section C:
Loss of Income

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Physician's Report

WHAT'S COVERED?

NON-MEDICARE EXAMPLES:

Ambulance

Physiotherapist

Dental

Private Hospital Accom.

Chiropractor

WHAT'S NOT COVERED?

MEDICARE EXAMPLES:

Doctor

Surgeon

Surgeon's assistant

Anaesthetist

X-Rays

Public Hospitals

Send completed forms to:

ECHELON CLAIMS SERVICES

GPO Box 1693

Adelaide, SA 5001

Or

Fax: (08) 8235 6450

Claims Enquiries:

Phone: 1800 640 009

www.jltsport.com.au

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Claim Conditions

How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
 - o Your claim form may be returned if there is important information missing
 - o For assistance, please contact Echelon on 1800 640 009
2. Send your completed claim form to Echelon **within 180 days from the date of injury**
 - o **Do not** wait until your treatments have concluded before you lodge your claim
 - o You can lodge your claim even if you have no out of pocket expenses
3. Echelon will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information
4. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to Echelon as your treatment continues (for up to 12 months from the date of injury).

What should I send with my claim?

Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to Echelon.

Retain a copy - Please submit only original receipts to Echelon. We recommend you retain a copy of all receipts and your Claim Form for your records.

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send Echelon a copy of your Private Health rebate advice.

Claims Conditions:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to Echelon within 180 days from the date of injury.

Subject to the Trustee's discretion and/or the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by Echelon must be provided by you upon request and at your expense (if applicable).

Who is Echelon?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of JLT. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the Australian Cricket National Club Risk Protection Programme.

Who is JLT Sport?

JLT Sport is the appointed broker for the Australian Cricket National Club Risk Protection Programme. As a division of Jardine Lloyd Thompson Pty Ltd, JLT Sport is Australia's leading provider of insurance and risk protection for the sport, recreation and fitness industries

Privacy:

We, JLT (including our subsidiaries and related entities), collect, store and use your personal details in accordance with the Privacy Act 1988 (and subsequent amendments).

We are collecting the information herein principally for the purpose of processing your Personal Injury Claim. Other purposes include providing risk management advice and statistical analyses to your sport.

By providing the information requested in this document, you agree to us collecting, using and disclosing your personal information as outlined in our Collection Statement available via www.jltsport.com.au

If you do not provide all or part of the information requested, we may not be able to process your application or you may prejudice your insurance cover.

You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.

To assist us in maintaining correct records we ask you to inform us of any changes to in your personal information provided, as they occur.

If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the conditions herein. Where the information relates to health or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent.

Our Privacy Policy is available upon request or you can access it anytime via our web site www.jltsport.com.au

Important Information

Claim Conditions

Section A:
Claimant's Details

Section B:
Club Declaration

Section C:
Loss of Income

Section D:
Physician's Report

Complete ALL sections

Send within 180 Days

Don't wait for treatment

Retain copies of all receipts

Retain a copy of your claim

Send completed forms to:

ECHELON CLAIMS SERVICES

GPO Box 1693

Adelaide, SA 5001

Or

Fax: (08) 8235 6450

Claims Enquiries:

Phone: 1800 640 009

www.jltsport.com.au

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Section A: Claimant's Details

PERSONAL INFORMATION:

Claimant's Name:

First Name

Surname

Postal Address:

Street Address

State

Postcode

Occupation:

Contact Details:

Email Address

Phone Number (Bus. Hours)

Personal Details:

/ /

☐ Male

☐ Female

Date of Birth

Gender

/ /

Date of Injury

AM PM

Time of Injury

Club Name:

Association Name:

Describe your injury and how it happened (please attached additional pages if required):

INJURY RESEARCH DATA:

Session: ☐ Playing ☐ Training ☐ Travelling ☐ Event ☐ Other ☐ Warm up/down

Location: ☐ Indoor ☐ Outdoor

Injured Person: ☐ Player ☐ Umpire ☐ Official ☐ Trainer ☐ Other

Grade: ☐ Senior ☐ Junior ☐ Not Applicable

Playing Position: ☐ Batting ☐ Bowling ☐ Fielding ☐ Umpiring ☐ Wicket Keeping

Surface Type: ☐ Asphalt ☐ Concrete ☐ Grass ☐ Indoor ☐ Timber ☐ Synthetic Grass

Weather Conditions: ☐ Fine ☐ Rain ☐ Extreme Heat ☐ Extreme Cold

Surface Conditions: ☐ Wet ☐ Dry ☐ Muddy ☐ Indoor ☐ Other

Resumption date(s):
When will you resume WORK?
When will you resume TRAINING?
When will you resume PLAYING?

Private Health Cover:

☐ Yes

☐ No

Do you have Private Health Insurance?

If YES, what is the name of your Private Health Insurance Provider?

Private Health Coverage:

☐ Dental

☐ Physiotherapy

☐ Ambulance

☐ Hospital

Ambulance Membership:

☐ Yes

☐ No

PAYMENT DETAILS:

EFT Payee Details:

Bank

Name on Account

BSB

Account Number

CLAIMANT DECLARATION:

By signing the declaration below, you confirm and agree to the following:

- The injury was sustained accidentally during a cricket activity and is not a pre-existing illness or condition.
- You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/cricketaustralia.
- You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).
- You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, the Trustee and the Claims Managers.
- You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish JLT's representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.
- You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.
- You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.

Claimant's Signature*

Date:

/ /

*Parent or Guardian if under 18 years

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Send completed forms to:

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GPO Box 1693

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Fax: (08) 8235 6450

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Section B: Club Declaration

CLUB DETAILS:

Claimant's Name:	<input type="text"/>	<input type="text"/>
	First Name	Surname
Club Name:	<input type="text"/>	
Club Contact:	<input type="text"/>	<input type="text"/>
	Club Contact Person	Position within Club
Contact Details:	<input type="text"/>	<input type="text"/>
	Contact Phone Number	Email Address
Association Name:	<input type="text"/>	
Registration Details:	<input type="radio"/> Yes <input type="radio"/> No	
	Is the Club Registered for this Period of Cover?	
Loss of Income Cover:	<input type="radio"/> Yes <input type="radio"/> No	\$ <input type="text"/> Per week
	If known > Has the Club purchased additional Loss of Income cover? (above the \$500 per week provided within the Programme) If YES, what is the weekly limit purchased by the Club (if known)?	

INJURY DETAILS:

Date/Time:	<input type="text"/>	<input type="text"/>	AM PM
	Date of Injury	Time of Injury	
Circumstances:	<input type="radio"/> Playing <input type="radio"/> Training <input type="radio"/> Travelling <input type="radio"/> Other		
Opposition Club Name:	<input type="text"/>		
	If applicable		
Ground/Location:	<input type="text"/>		
	Where did the injury occur?		
Resumption date(s):	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	
	Has the Claimant returned to TRAINING?	If YES, date Claimant returned?	
	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	
	Has the Claimant returned to COMPETITION?	If YES, date Claimant returned?	

CLUB DECLARATION:

By signing the declaration below, you confirm and agree to the following:

- A. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).
- B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
- C. You declare the Claimant's injury was sustained accidentally during the cricket activity noted above and is not a pre-existing illness or condition.
- D. You understand that registering your club with JLT Sport is a requirement of the Australian Cricket National Club Risk Protection Programme for each Period of Cover.
- E. You confirm the club's level of cover as per the details provided above.

Club Representative's
Signature:

Date:

Important Information

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Please check your that your
club has purchased
Loss of Income Cover

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Section C: Loss of Income

TO BE COMPLETED BY THE CLAIMANT:

Do you wish to claim Loss of Income Benefits? ☐ Yes ☐ No If NO, proceed to SECTION D

If you are NOT claiming Loss of Income Benefits please do not complete this section. Please proceed to Section D.

Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)? ☐ Yes ☐ No

Have you ever made previous claims in respect to a personal accident insurance policy or plan? ☐ Yes ☐ No

Have you engaged in any other income earning employment since you became injured? ☐ Yes ☐ No

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):

Claimant's Name:

First Name

Surname

Employer/Business:

Employer/Company Name

Contact Person

Postal Address:

Street Address

State

Postcode

Contact Details:

Email Address

Phone (Bus. Hours)

Mobile

Employment Status: ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed

Employment Details: \$ / \$ /
Employee's NET weekly salary Employee's GROSS week salary Date Employee commenced with company.
If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.

Injury Details: / / / /
Date employee ceased work Date expected to resume duties

Returned to Work: ☐ Yes ☐ No / /
Has the Employee returned to work? If YES, what date did the Employee return?

Salary Received: ☐ Yes ☐ No If YES, what for?
During the period of incapacity, has the employee received a salary?

Sick Leave: ☐ Yes ☐ No from / / to / /

Annual Leave: ☐ Yes ☐ No from / / to / /

Other: ☐ Yes ☐ No from / / to / /

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances.
Excludes income derived from playing sport.

EMPLOYER'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

- A. You are the Claimant's current employer (or accountant if the claimant is self-employed),
- B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,
- C. You will supply upon request any further information as required for the determination of this claim.

Employer's Signature:

* Accountant's signature (if claimant is self-employed)

Date:

/ /

For more information, please refer to JLT Sport's web site:

www.jltsport.com.au/cricketaustralia

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Please check your that your club has purchased Loss of Income Cover

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Section D: Physician's Report

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

PHYSICIAN'S REPORT

Claimant's Name:

First Name

Surname

Physician's Details:

Physician's Name

Phone Number

Injury Consultation:

/ /

/ /

Date of Injury

Date of Consultation

Diagnosis/History of injury:

Injury Location:

☐ Ankle

☐ Arm

☐ Dental

☐ Facial

☐ Foot

☐ Hand

☐ Head

☐ Internal

☐ Knee

☐ Lower Leg

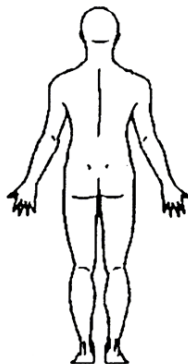
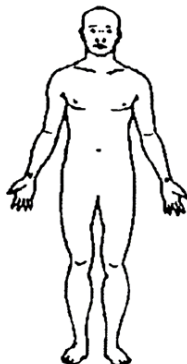
☐ Shoulder

☐ Spinal

☐ Torso

☐ Upper Leg

Please mark (x) the anatomical location below:



Injury Type:

☐ Amputation

☐ Bruising

☐ Concussion

☐ Cut

☐ Death

☐ Dental

☐ Dislocation

☐ Fracture/Break

☐ Rupture

☐ Sprain

☐ Strain

☐ Fatigue/Debilitation

First Medical Treatment:

/ /

Date of treatment

Name of attending physician

Do you consider the Claimant's injury to be a NEW injury?

☐ Yes

☐ No

Do you consider the Claimant's injury to a recurrence of a previous injury?

☐ Yes

☐ No

If YES, please provide details and a description:

Does the Claimant have any congenital defects or chronic diseases?

☐ Yes

☐ No

If YES, please provide details and a description (dates, name of treating doctor, etc):

Please continue to Page 7.

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Section D: Physician's Report

PHYSICIAN'S REPORT (continued)

Have you referred the patient to any other services or treatment?

☐ Yes ☐ No

If YES, please provide details below:

Physiotherapy: ☐ Yes ☐ No

If YES, approx. number of treatments required.

Chiropractics: ☐ Yes ☐ No

If YES, approx. number of treatments required.

Surgery: ☐ Yes ☐ No

If YES, please provide details

Other: ☐ Yes ☐ No

If YES, please provide details

Has the Claimant been able to do any work since the injury occurred?

☐ Yes ☐ No

What date do you advise the Claimant to return to playing Cricket?

If YES, please provide details

PHYSICIAN'S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

- A. You have examined the Claimant's injury as described on this form;
- B. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Signature:

Date:

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT:

I, _____ examined _____ on ____/____/____
Medical Practitioner's Name Claimant's Name Date of examination

In my opinion, this person is/has been unfit to work from ____/____/____ to ____/____/____ inclusive.
First day of incapacity Last day of incapacity

Please provide any further comments in regard to your assessment of the injury/condition?

By signing the declaration below, you confirm and agree to the following:

- A. You have examined the Claimant's injury as described on this form;
- B. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature:

Date:

For more information, please refer to JLT Sport's web site:

www.jltsport.com.au/cricketaustralia



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