



OAMPS Sports Risk Management

CLAIM FORM

# Basketball Australia Insurance

# Sports Insurance Claim Form

1. Please complete Parts 1,2,3,4,5,6,7 and 8 of this claim form (pages 2 and 3), plus the injury data collection questions on pages 5 and 6
2. Ask Your doctor to complete the 'Medical Statement' (pages 7 and 8)
3. If Your claim is for loss of earnings:
  - (a) Ask Your employer to complete Part 9 (page 4). If You are self-employed please have Your accountant complete these details
  - (b) Forward a medical certificate every two weeks if Your disability is continuing
4. An authorised official of Your club must complete Part 10 (page 4)
5. Please refer to 'Notes for claimants' on page 9

## The Association

**1**

Sport played			
Regional body			
Association name			
Club			
Team			
Age group			
Grade	<input type="checkbox"/>	Seniors	<input type="checkbox"/>
		Reserves	<input type="checkbox"/>
	(if applicable)		

## The Member

**2**

Name			
Address			
		P/code	
Phone	Work <input type="checkbox"/>	Mobile	<input type="checkbox"/>
Email Address			
Occupation			
Date of Birth	..... / ..... / .....	Sex: Male	<input type="checkbox"/>
		Female	<input type="checkbox"/>
Registration number (If Known)			

## Details of the Member's Disability or Injury

**3**

What is the nature of Your injury?			
What body part/s has been injured?			
Is it a recurrence of a previous injury?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
How did it happen?			
Where were You when it happened?			
Type of location	Sportsground <input type="checkbox"/>	Gymnasium	<input type="checkbox"/>
	Other <input type="checkbox"/>	Swimming pool	<input type="checkbox"/>
If 'Other' please describe			
When did the injury occur?	Date: ..... / ..... / .....	Time:	
What were <b>You</b> doing?	Playing a match <input type="checkbox"/>	Warm up	<input type="checkbox"/>
	Other sport <input type="checkbox"/>	Gradual onset	<input type="checkbox"/>
What was the event?	Competition <input type="checkbox"/>	Regular training	<input type="checkbox"/>
	Private training <input type="checkbox"/>	Other	<input type="checkbox"/>
If 'Other' please describe			

## Details of the Member's treatment

4	Name and address of each hospital <b>You</b> attended	
	Date of Admission: ..... / ..... / ..... Discharge: ..... / ..... / .....	
	Name, address and phone numbers of all attending doctors	
	Name, address and phone number of <b>Your</b> usual doctor	

## Details of the Member's previous Disabilities, injuries or claims

5	Were <b>You</b> suffering any previous medical condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'Yes', give details of the condition		
	Have <b>You</b> ever made a claim under a sports' injury or personal accident insurance policy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'Yes', what was the date of injury	..... / ..... / .....	
	Who was the insurer?		
	How much were <b>You</b> paid?		
	What was the injury?		
	Name and address of the doctor		
		P/code	

## Details of the Member's insurance

6	Are <b>You</b> a member of a health fund	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	If 'Yes', what type of membership do <b>You</b> have?	Hospital cover only <input type="checkbox"/>	Ancillary cover only <input type="checkbox"/>	Hospital plus ancillary benefits <input type="checkbox"/>
	Name of health fund			
	Membership number			
	Any other details regarding private health cover			
	Do <b>You</b> have any other insurance to cover this disability or Injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	If 'Yes', please show name and address of insurer			
		P/code		

## Drugs and intoxicating liquor

7	Were <b>You</b> under the influence of any drug or intoxicating liquor when the disability or injury took place	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'Yes', please give details		
	Have You taken any performance enhancing drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## The Member's declaration

8	By signing this claim form I declare that	<ol style="list-style-type: none"><li>All the information that I have given in this form is correct</li><li>I authorise any doctor, hospital or other person who has treated me to provide OAMPS Insurance Brokers Ltd. or its representative with any medical records for any illness or injury I have suffered.</li><li>I authorise my employer to provide OAMPS Insurance Brokers Ltd. or its representative with details of my salary and working hours.</li><li>I agree that a photocopy of this authorisation will be accepted as valid.</li><li>I agree to allow the insurer to ask or tell other insurers or insurance reference bureaux about this or any other claim I have made.</li></ol>
	Must be completed by the injured <b>Member</b> or their guardian if the member is under 18 years	
	Signature	
	Date	..... / ..... / .....

**The Member's employment details** (Must be completed by pay clerk/paymaster)

9

Employer's name			
Employer's address			
	P/code		
Phone number			

What was your employee's gross weekly income at the date of injury for the 12 calendar months immediately preceding injury.  
(excluding bonuses, commissions, overtime or any other allowances)

\$										p.w.
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Date **You** expect **Your** employee to resume work ..... / ..... / .....

Date **You** expect **Your** employee to resume normal duties (fully fit) ..... / ..... / .....

What is **Your** employee's gross annual salary? \$

What date did he or she commence employment? ..... / ..... / .....

If self-employed please attach proof of income over the past 12 calendar months immediately preceding injury (net of business expenses, but before income tax and personal deductions e.g. Tax Return).

What is the name of Your pay clerk?	
What is Your pay clerk's phone number?	
Signature of pay clerk / paymaster	
Date	..... / ..... / .....

**The Club's declaration**

10

Must be completed by the club Secretary or Treasurer

If the Player was injured participating in a game please attached a copy of the team sheet to this claim form

State Association/OAMPS Office Use Only	
Player Registration Number	.....
Signed	.....
Position	.....
State Association Stamp Where Applicable	

I	.....	Secretary or Treasurer
of	.....	Name of club and association
Confirm that	.....	Member's name
Sustained the injuries resulting in this claim on	.....	
	.....	Date
	.....	at
	.....	time
While playing or training for	.....	Team
against	.....	Opposition Team
or while taking part in	.....	Activity
against	.....	Opposition Team
at	.....	Place of game or activity
The first consultation with a doctor for this injury was on	.....	
	.....	Date
at	.....	Address of doctor
Signature		

Date ..... / ..... / .....

Club mailing address			
	P/code		
Phone number			

# Injury data collection

OAMPS Insurance Brokers Ltd is committed to Safer Sport. Analysis of sporting injuries is critical to implementing injury prevention strategies. OAMPS Insurance Brokers Ltd, in association with your sport and with your cooperation, is being proactive in collecting injury data with the aim of decreasing injuries. Thank you for assisting with this project.

What was Your role at the time of Your injury?	Participant <input type="checkbox"/>	Coach <input type="checkbox"/>	Umpire/Referee <input type="checkbox"/>
	Other Official <input type="checkbox"/>	Voluntary Worker <input type="checkbox"/>	Spectator <input type="checkbox"/>
	Other <input type="checkbox"/>		
If other, please provide details			
How far into the activity were You at the time of the injury? (Note: Your answer relates to the time into the activity, rather than the period/stage of the game)	Warm up <input type="checkbox"/>	1st Quarter <input type="checkbox"/>	2nd Quarter <input type="checkbox"/>
	3rd Quarter <input type="checkbox"/>	4th Quarter <input type="checkbox"/>	
	Cool Down <input type="checkbox"/>		
On what surface were You participating?	Grass <input type="checkbox"/>	Synthetic Surface <input type="checkbox"/>	Wooden Floor <input type="checkbox"/>
	Gravel <input type="checkbox"/>	Concrete/Bitumen <input type="checkbox"/>	Other <input type="checkbox"/>
If 'Other', please provide details			
What was the condition of the surface?	Normal <input type="checkbox"/>	Hard <input type="checkbox"/>	Wet <input type="checkbox"/>
	Other <input type="checkbox"/>		Muddy <input type="checkbox"/>
If 'Other', please provide details			
What were the weather conditions as the time of injury?	Fine <input type="checkbox"/>	Light Rain <input type="checkbox"/>	Heavy Rain <input type="checkbox"/>
			Other <input type="checkbox"/>
If 'Other', please provide details			
What were the temperature conditions as the time of injury?	Very Hot <input type="checkbox"/>	Hot <input type="checkbox"/>	Hot & Humid <input type="checkbox"/>
	Cold <input type="checkbox"/>	Very Cold <input type="checkbox"/>	Other <input type="checkbox"/>
			Mild <input type="checkbox"/>
If 'Other', please provide details			
How was the onset of injury?	Sudden <input type="checkbox"/>	Gradual <input type="checkbox"/>	
	Started Play With Pre-Existing Injury <input type="checkbox"/>		
If a collision injury, what did You collide with?	Ground <input type="checkbox"/>	Equipment <input type="checkbox"/>	Player <input type="checkbox"/>
	Other Structure <input type="checkbox"/>		
If 'Other', please provide details			
What was Your activity leading to the injury?	Landing <input type="checkbox"/>	Jumping <input type="checkbox"/>	Twist/Turn <input type="checkbox"/>
	Side Stepping <input type="checkbox"/>	Starting <input type="checkbox"/>	Stopping <input type="checkbox"/>
	Running <input type="checkbox"/>	Applying Tackle <input type="checkbox"/>	Being Tackled <input type="checkbox"/>
	Receiving Ball <input type="checkbox"/>	Passing/Throwing <input type="checkbox"/>	Hitting <input type="checkbox"/>
	Kicking <input type="checkbox"/>	Scrum <input type="checkbox"/>	Ruck <input type="checkbox"/>
	Maul <input type="checkbox"/>	Other <input type="checkbox"/>	
If 'Other', please provide details			
Was protective equipment, tape or support being worn on the injury site?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please provide details	Taping <input type="checkbox"/>	Protective Equip. <input type="checkbox"/>	Other Support <input type="checkbox"/>
If protective equipment, please provide details			
If other support, please provide details			
How did the injury severity affect Your playing?	Unable to Continue Playing <input type="checkbox"/>		
	Continued to Play After Treatment <input type="checkbox"/>		
	Continued to Play Without Treatment <input type="checkbox"/>		
What was the immediate treatment? (more than one box may be ticked)	Rest <input type="checkbox"/>	Ice <input type="checkbox"/>	Compression <input type="checkbox"/>
	Elevation <input type="checkbox"/>	Stretching <input type="checkbox"/>	Mobilisation <input type="checkbox"/>
	Taping <input type="checkbox"/>	Bandaging <input type="checkbox"/>	Sling <input type="checkbox"/>
	Splint <input type="checkbox"/>	Other <input type="checkbox"/>	Unknown <input type="checkbox"/>
If 'Other' please provide details			
Was a sports trainer present at the game?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>

If Your injury required referral, to whom were **You** referred?

Hospital	<input type="checkbox"/>	Doctor	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	Other	<input type="checkbox"/>		

If 'Other' please provide details

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If immediate off site treatment was necessary,

What mode of transport was used?

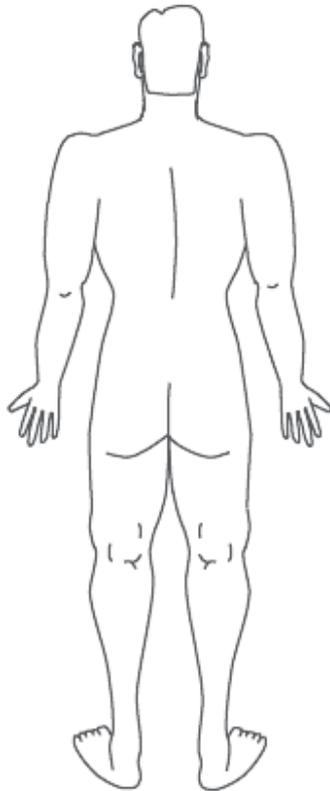
Ambulance	<input type="checkbox"/>	Private Vehicle	<input type="checkbox"/>	Other	<input type="checkbox"/>
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If 'Other', please provide details

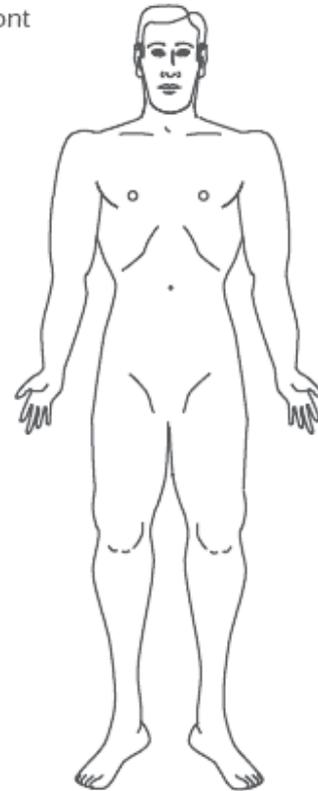
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Please indicate the site of your injury on  
The appropriate diagram below

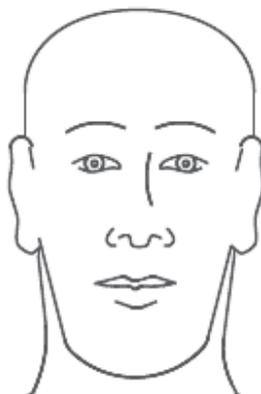
Back



Front



Head



# Medical statement

This form must be completed by the registered medical doctor treating the injury

## The Association and Club

Association name	<input type="text"/>		
Club name	<input type="text"/>		
Type of sport	<input type="text"/>		

## The Member

Name	<input type="text"/>		
Address	<input type="text"/>		
		P/code	<input type="text"/>
Age	<input type="text"/>	Gender	<input type="text"/>

## The injury

### Complete Diagnosis

<input type="text"/>
<input type="text"/>
<input type="text"/>

### History

When did the present disability or injury occur?

Date the player ceased work ..... / ..... / .....

Is there a history of the same or similar condition?

Is this a recurrence? Yes  No

### Present condition

Subjective symptoms

Objective finding

(give reports of any x-rays, ECGs or other tests)

Is the player Walking  Bed confined  House confined

Hospital confined  Date of admission: ..... / ..... / .....

### Treatment of present condition

Date of first consultation ..... / ..... / .....

Date of latest consultation ..... / ..... / .....

Frequency of consultations

Date of last hospitalisation ..... / ..... / .....

Name of hospital

Nature of surgical procedure

Contemplated  Performed

### Progress

If performed Date: ..... / ..... / .....

Has condition improved? Yes  No

If 'No', please explain



## Notes for claimants

To ensure your claim is processed quickly and efficiently please follow steps below. Please read thoroughly and keep for your own reference

### Non Medicare medical expenses claim

1. **Please note that due to Federal Government Legislation (Sec126, Health Insurance Act 1973) General Insurers are unable to provide benefits on any Medicare related expenses, including gap payments.**
2. Refer to instructions on page 2 of claim form.
3. Claims for treatment given by a chiropractor, masseur, naturopath, osteopath or physiotherapist must be accompanied by a referral from a registered medical doctor.
4. If you hold private health insurance you are required to claim all expenses from your private health fund first. Once you have claimed from your health fund please forward your 'Statement of Benefits Paid', the account and receipt to us.
5. If you have already incurred non-Medicare medical expenses, please attach the original tax invoices along with a receipt confirming the account has been paid.

### Loss of income claim

1. Refer to instructions on page 2 of claim form.
2. If you are self-employed have your accountant complete 'The Member's Employment Details' and supply us with a copy of your last tax assessment.
3. If you are an employee please forward payslips for the four weeks preceding your injury, or a letter from your employer on company letterhead confirming the gross amount earned per week for the four weeks preceding your injury.
4. Loss of income payments will not be made until the Medical Statement, medical certificates and proof of earnings are received.

### Important

1. **Your claim cannot be processed if the claim forms are incomplete or illegible. To ensure your claim is processed without delay please make certain all sections on the *Sports Injury Claim Form, Medical Statement, Injury Data Collection* questionnaire and any applicable *Addendums to Injury Data Collection* questionnaires are fully complete**
2. **Please forward your completed Sports Injury Claim Form to our office within 30 days of your injury. Do not wait for all your medical accounts. Forward them to us as you receive them.**
3. **Your Personal Accident Sports insurance policy covers medical expenses incurred within 365 days of the date of the event that caused the injury.**

If you have any questions or problems please contact us, we are always ready to help.

## Complaints and disputes

If you are dissatisfied with a product or service provided by your Adviser, please contact the Manager of the Branch in your State.

If the Branch Manager is unable to resolve the complaint to your satisfaction, you may ask that the matter be referred to the National Complaints Manager for OAMPS Insurance Brokers Ltd. The National Complaints Manager will acknowledge your complaint in writing and endeavour to resolve your problem within 20 working days.

If you remain dissatisfied, you have the right to refer to your complaint to the Insurance Brokers Disputes Ltd. (IBD). Each of the licenced entities subscribes to the external facility for the handling of complaints. You can refer your complaint to an IBD Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

If either you or OAMPS reject the IBD Case Manager's finding and the dispute remains unresolved, it will be referred to the IBD's Referee whose decision is binding on us (but not on you). Further information about the IBD is available for all OAMPS Insurance Brokers Ltd offices.

## Claims Handling

Claims are processed at OAMPS Brisbane office (refer address below). To maximise claims handling efficiency send your completed claim form and documentation direct to that office.

### OAMPS Capital City Offices

#### Adelaide

168 Greenhill Road  
Parkside, Adelaide, SA 5063  
T: (08) 8172 8000  
F: (08) 8172 8100

#### Brisbane

Lvl 2, 8 Gardner Close  
Milton, Brisbane, QLD 4064  
T: (07) 3367 5000  
F: (07) 3367 5100

#### Canberra

Ground Floor, 10 Geils Court  
Deakin ACT 2600  
T: (02) 6283 6555  
F: (02) 6283 6556

#### Darwin

Lvl 2, 71 Smith Street  
Darwin, NT 0801  
T: (08) 8942 5000  
F: (08) 8942 5050

#### Hobart

Lvl 4, 85 Macquarie Street  
Hobart, TAS 7000  
T: (03) 6235 1222  
F: (03) 6235 1221

#### Melbourne

289 Wellington Parade South  
East Melbourne, VIC 3002  
T: (03) 9412 1555  
F: (03) 9412 1666

#### Perth

Lvl 1, 21 Teddington Street  
Burswood, WA 6100  
T: (08) 6250 8300  
F: (08) 6250 8400

#### Sydney

Lvl 4, 2-12 Macquarie Street  
Parramatta, NSW 2150  
T: (02) 8838 5700  
F: (02) 8838 5701