V-INSURANCE GROUP
CORPORATE AUTHORISED REPRESENTATIVE OF Willis

Office use only
Policy Number: .....
Claim Number: .....

BMX AUSTRALIA

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Fullerton Health Corporate Services
Level 10, 33 York Street
Sydney NSW 2000

Email: claims@fullertonhealthcs.com.au
Phone: (02) 8256 1770 Fax: (02) 8256 1775

V-INSURANCE GROUP
CORPORATE AUTHORISED REPRESENTATIVE OF WILLIS

INSURANCE BROKER FOR BMX AUSTRALIA;
Authorised Representative No. 432898 a corporate
authorised representative of Willis Australia Limited AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547

BMX AUSTRALIA
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of Accidental Death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $50,000 for events and $25,000 all other times (other than anyone under 18 years of age where the benefit is $20,000 and over 65 years old the benefit $25,000 maximum). The paraplegia and quadriplegia benefit is $100,000 for events and $50,000 all other times.

Non Medicare Medical Expenses

Reimburses 80% of Non-Medicare medical expenses up to a maximum of $2,500 for events and $1,500 all other times and $5,000 for Voluntary Workers. Some claimable expenses include but are not limited to private hospital, ambulance, dental, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance, must have health cover for the expense claimed or $100 for claimants who do not have private health insurance. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

100% cover for ambulance only up to the above limits

Loss of Income

Cover for 75% of your gross income or up to a maximum of $250 per week, whichever is the lesser. The benefit period is Thirty Nine (39) weeks and the excess is 21 days.

Parents Inconvenience Allowance

Up to $25 per day to a maximum of $1,500 for reasonable costs incurred by the parents of an insured person who is a full time student whilst their child is undergoing medical. The maximum benefit period is 52 weeks and the policy excess is 14 days.

Special Note: Freestyle Members only covered for Non Medicare Medical Expenses.

Important Notes

This insurance cover is issued by: Pen Underwriting Pty Ltd
ABN 89 113 929 516 AFSL 290518 as Coverholder on behalf of certain Underwriters at Lloyd's
Level 19, 347 Kent Street Sydney NSW 2000

1. This summary of insurance cover provides factual information about the BMX Australia Insurance Program as contained in the Product Disclosure Statement (PDS). Cover is subject to the full terms, conditions and exclusions contained in the PDS. Certain terms used in this summary are defined in the PDS.
2. The policy with full terms, conditions and exclusions is available at http://www.bmxaustralia.com.au/ or by contacting BMX Australia.
3. This insurance program commenced on 30 November 2018 and expires on 30 November 2019.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of BMX Australia who, through injury or accident, incur financial loss and who would not have otherwise received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
5. BMX Australia are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the BMX Australia insurance program can be obtained by visiting http://www.bmxaustralia.com.au

HOW TO MAKE A CLAIM

Dear BMX Australia member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed as truthfully and accurately as possible. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

2. Please ensure that you fully complete pages 4, 5 & 6 and sign and date the Declaration.

3. For claims involving Loss of Income:

a) You must complete page 7 and have your employer/salary officer complete page 7. If self-employed, you must have your accountant complete these details;

b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 9.

4. For claims involving Non-Medicare medical expenses, complete page 8:

Medical treatment must be certified necessary by an attending physician and incurred within Australia.

a) Have your Attending Physician complete the "Attending Physician" statement on pages 9 and 10.

5. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit the insurer to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital bed and theatre fees, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

1. Once you have completed your claim form, please forward to Fullerton Health Corporate Services as agents of Pen Underwriting Pty Ltd. Their contact details are as follows;

Fullerton Health Corporate Services
Level 10, 33 York Street
Sydney NSW 2000

Email: claims@fullertonhealthcs.com.au
Phone: (02) 8256 1770 Fax: (02) 8256 1775

2. Your reimbursement will be sent to you directly by Fullerton Health Corporate Services.

3. Once your claim is registered, you can submit ongoing invoices via Fullerton Health Corporate Services who can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

4. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance Group on: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Claimant's Given Name:		Surname:	
Name of Club:	Age group/grade:		Member No
Occupation:	Date of Birth: / /	Gender (please tick): ☐ Male ☐ Female	Email:
Address			State Postcode
Phone Number (work): ( )	Home ( )		Mobile

Please tick the category applicable ☐ Rider ☐ Official ☐ Coach ☐ Other

If Other, please advise_____

Please confirm which type of membership you hold with BMXA;

☐ BMX ☐ Freestyle

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I_____(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Pen Underwriting Pty Ltd to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Pen Underwriting Pty Ltd and their service providers in order to assess the claim. Pen Underwriting Pty Ltd complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant _____Date _____

(or Legal Guardian if under 18 years of age)

Office use only
Policy Number: .....
Claim Number: .....

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 ( )
- Club Training ( )
- Individual Training ( )
- Travelling to and from activity ( )
- Sanctioned fundraising/social event ( )
- Other: _____

At the time of the accident were you:

- Representing Australia at Olympic Games ( )
- Representing Australia at Commonwealth Games ( )

Please provide the address of where the injury occurred:

State the name of any one witness to the injury:	Address 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?	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?	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?	If yes, please advise when: / /

The following information is required for BMX Australia research to assist with Risk Management. <u>Answering these questions will not affect your claim.</u>		
Surface at point of injury? (please tick)	Road	( )
	Bike Path	( )
	Dirt/Gravel	( )
	BMX Track	( )
	Other: _____	
Weather conditions? (please tick)	Fine	( )
	Rain	( )
	Showers	( )
	Extreme Heat	( )
	Extreme Cold	( )

LOSS OF INCOME

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(Please tick the box)	YES	NO
1. Can compensation be claimed under Workers Compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER / SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer: State Postcode	
Date ceased work due to injury: / /	Date expected to resume normal duties: / /
Employee weekly salary as at date of injury: Gross $..... If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

☐ Self Employed ☐ Full Time ☐ Part Time ☐ Casual

During the period of incapacity the employee has received

$.....	Normal Pay	From	……/……/……	to	……/……/……
$.....	Sick Pay	From	……/……/……	to	……/……/……
$.....	Workers Compensation	From	……/……/……	to	……/……/……
$.....	Other (please specify)	From	……/……/……	to	……/……/……

Has the employee returned to work? ☐ Yes ☐ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ☐ Yes ☐ No

A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountant's Company Stamp:	Date: / /

NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act 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

Extra's covering, 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 E.G DENTAL PHYSIOTHERAPY ETC	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:.....

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AR No. 432898 Willis Australia Limited AFSL: 240600
Phone (02) 8599 8660 or local call cost only 1300 945 547
Please send completed claim forms and supporting documentation to
Fullerton Health Corporate Services
Level 10, 33 York Street, Sydney NSW 2000
Phone: +61 2 8256 1770 Email: claims@fullertonhealthcs.com.au

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT
(PLEASE PRINT LEGIBLY)

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can only be completed by the treating Doctor / Specialist Doctor.**
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

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? / /

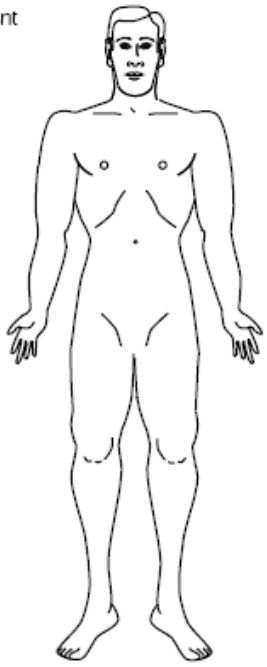
Are you the patient's regular general practitioner? ☐ Yes ☐ No

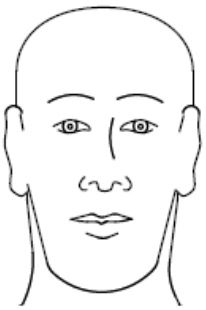
If not, please advise who is .....

What is the exact nature of the present injury? _____

_____

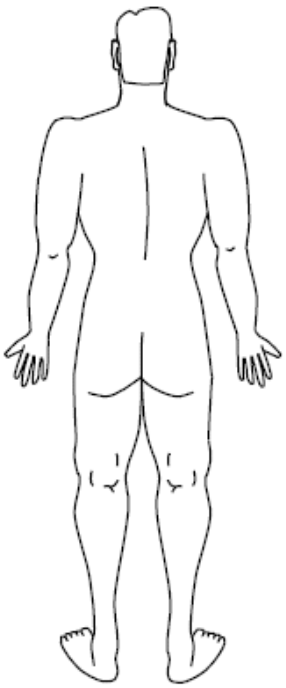
Front





Head

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, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to BMX?

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 Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....

METHOD OF PAYMENT

Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account

Please indicate your preferred method of payment (please tick) ☐ Cheque ☐ EFT

If you would like your payment made by EFT, please complete the details below.

NAME OF CLAIMANT

Title: ☐ Mr. ☐ Mrs ☐ Ms ☐ Miss

Name:_____

BANK ACCOUNT DETAILS

BSB number (all 6 digits are required here) Account Number

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch:_____

DECLARATION

I hereby authorise Fullerton Health Corporate Services Pty Ltd to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment.
- Fullerton Health Corporate Services is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Fullerton Health Corporate Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Fullerton Health Corporate Services's disclosure of this information, to Fullerton Health Corporate Service's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988.* I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.

Signature: _____ Date: _____

Print Name: _____