



OAMPS Sports Risk Management

SPORTS INSURANCE Claim Form



Sports Insurance Claim Form

1. Please complete Parts 1 - 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 you are covered for loss of earnings and you wish to make a claim in that regard:
 - (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
6. To maximise claims handling efficiency send your completed claim form to the OAMPS office in your nearest capital city. Refer to the bottom of page 9 for office addresses.

1 The Association

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

2 The Member

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)			

3 Details of the Member's Disability or Injury

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"/>	Swimming pool <input type="checkbox"/>
	Other <input type="checkbox"/>		
If 'Other' please describe			
When did the injury occur?	Date: / /	Time:	
What were You doing?	Playing a match <input type="checkbox"/>	Warm up <input type="checkbox"/>	Training <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"/>	Training camp <input type="checkbox"/>
	Private training <input type="checkbox"/>	Other <input type="checkbox"/>	
If 'Other' please describe			

4 Details of the Member's treatment

Name and address of each hospital **You** attended

Date of Admission: / / Discharge: / /

Name, address and phone numbers of all attending doctors

Name, address and phone number of **Your** usual doctor

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

Were **You** suffering any previous medical condition?

Yes No

If 'Yes', give details of the condition

Have **You** ever made a claim under a sports' injury or personal accident insurance policy?

Yes No

If 'Yes', what was the date of injury

..... / /

Who was the insurer?

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How much were **You** paid?

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What was the injury?

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Name and address of the doctor

P/code

6 Details of the Member's insurance

Are **You** a member of a health fund

Yes No

If 'Yes', what type of membership do **You** have?

Hospital cover only Ancillary cover only Hospital plus ancillary benefits

Name of health fund

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Membership number

--

Any other details regarding private health cover

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Do **You** have any other insurance to cover this disability or Injury?

Yes No

If 'Yes', please show name and address of insurer

P/code

7 Drugs and intoxicating liquor

Were **You** under the influence of any drug or intoxicating liquor when the disability or injury took place

Yes No

If 'Yes', please give details

Have You taken any performance enhancing drugs?

Yes No

8 The Member's declaration

By signing this claim form I declare that

Must be completed by the injured **Member** or their guardian if the member is under 18 years

- All the information that I have given in this form is correct
- 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.
- I authorise my employer to provide OAMPS Insurance Brokers Ltd. or its representative with details of my salary and working hours.
- I agree that a photocopy of this authorisation will be accepted as valid.
- 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.

Signature

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Date / /

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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
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	<input type="text"/>		
If other support, please provide details	<input type="text"/>		
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	<input type="text"/>		
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?

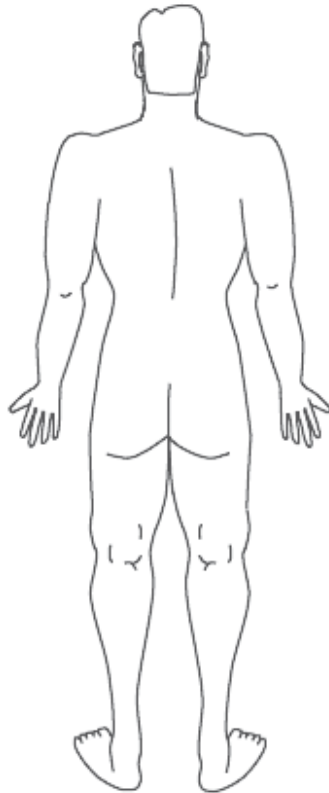
Ambulance	<input type="checkbox"/>	Private Vehicle	<input type="checkbox"/>	Other	<input type="checkbox"/>
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If 'Other', please provide details

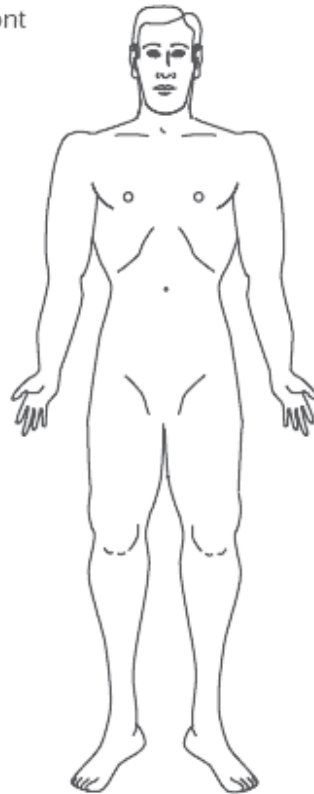
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Please indicate the site of your injury on
The appropriate diagram below

Back



Front



Head



Medical statement

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

The Association and Club

Association name			
Club name			
Type of sport			

The Member

Name			
Address			
		P/code	
Age		Gender	

The injury

Complete Diagnosis

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

Degree of disability

Has the patient been able to do any work?

If 'No', from what date Regular work: / / Light duties: / /

When will the patient be able to resume for Regular work: / / Light duties: / /

Other treatment

If the patient was seen in consultation by another doctor, / /
please give the date, name and address of that doctor.

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

If the patient is no longer under your care,
What date were your services terminated? / /

Other conditions

Describe any other disease or infirmity
Affecting the patient's present condition

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

Cardiac-circulatory

Please complete the appropriate section if the disability or injury is due to:

Blood pressure

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

Circulatory disorder – please describe

Visual

Is the patient totally or industrially blind?
If 'No', what was the vision at last observation

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
With glasses: Distant	<input type="checkbox"/>	Near	<input type="checkbox"/>	Date:	/..... /.....
Without glasses: Distant	<input type="checkbox"/>	Near	<input type="checkbox"/>	Date:	/..... /.....

What is the extent of any gross visual field defect?

Could vision be improved by treatment, surgery or lenses?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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What are the rehabilitation prospects?

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

Orthopedic

Please report findings of specialist if referred?

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

Neurological

Please report findings of specialist if referred?

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

Prognosis

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

Remarks

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

Please apply doctors name stamp below

Signature

<input type="text"/>

Date / /

Degree

<input type="text"/>

Name of Doctor (please print)

<input type="text"/>

Address

<input type="text"/>

P/code

<input type="text"/>

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 (if eligible)

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 your complaint to the Insurance Broking Division of the Financial

Ombudsman Service (FOS). Each of the licenced entities subscribes to this external facility for the handling of complaints.

You can refer your complaint to an FOS Case Manager who will conciliate with a view to seeking a solution that is acceptable to both parties.

Privacy

We are committed to protecting your privacy. We do not trade, rent or sell your information. For more information about our Privacy Policy please visit the OAMPS web site at www.oamps.com.au or telephone 1800 240 432.

OAMPS Capital City Offices

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