AFA INSURANCE

SPEEDWAY AUSTRALIA

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SPEEDWAY AUSTRALIA

ACCIDENT INJURY CLAIM FORM

To assist in the speedy processing of your claim, please follow the instructions for completion of these forms and forward them to Speedway Australia at the above address, together with Medical Certificates and relevant receipts. Incomplete claim forms will be returned for completion, leading to assessment delays.

The issue of this form does not constitute an admission of liability on the part of the Insurer.

IMPORTANT NOTE

DO NOT forward claim forms directly to the Insurer. ***Forward*** all claims with a copy of your licence to the Speedway Australia office.

DO NOT forward unpaid medical or ambulance accounts with Claim Forms.
All accounts should be paid and receipts forwarded with Claim Form for re-imbursement.

DO NOT forward copies of accounts or receipts. All accounts and receipts should be originals.

DO NOT forward Medicare accounts.

THERE ARE THREE SECTIONS TO THIS CLAIM FORM.

Section One, **CLAIMANT CERTIFICATION** is to be completed by the person making the claim (injured person) and must be completed for all claims. There are three pages.

Section Two, **MEDICAL CERTIFICATION**, is to be completed by the **registered medical practitioner** who is/or has been involved in treating the person making the claim and needs to be completed for all claims (Any fee incurred for completion of this part of the form is the responsibility of the person making the claim). There is one page.

Section Three, **SPEEDWAY AUSTRALIA CERTIFICATION.**
Once the injured person has completed section 1 and their treating medical practitioner has completed section 2, the injured persons needs to forward the form to Speedway Australia administration, who must complete section 3. There is one page.

ALL SECTIONS OF THE CLAIM FORM MUST BE COMPLETED IN FULL BEFORE A CLAIM CAN BE ASSESSED.

When the claim form has been completed in full, signed and dated please send it, **WITH ATTACHMENTS**, to:-

Speedway Australia
PO Box 269
STEPNEY SA 5069
email: admin@speedwayaustralia.net.au
www.speedwayaustralia.net.au

If you have any inquiries, or if you need assistance with understanding or completing this form, you may Contact Speedway Australia . Please ensure that you keep copies of all documentation sent to Speedway Australia. All correctly completed documentation received by Speedway Australia will be forwarded to the insurers who will make direct contact with you.

NOTE: This form is used to initiate a claim – if you continue to be disabled – and you are claiming for loss of income - you will be sent further progress forms for completion and return on a regular basis

SECTION 1 CLAIMANT CERTIFICATION

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM

Name of Club or Association:_________________________Speedway at which Accident Occurred:________________

Section Competing in at time of Accident___________________ NOTE: YOU MUST ATTACH A COPY OF YOUR LICENCE

A. TYPE OF CLAIM

Which benefit are you claiming for? **POLICY NUMBER: 5493872**

( ) **Medical expenses**

( ) **Loss of income** (Note: - check with your member organisation that you have this cover)

B. YOUR DETAILS

First names: (Mr/Mrs/Ms)____ Family Name:_____________________________________

Date of birth: ____/_____/_____ Medicare Number: __________________________________

Your address____Suburb/town_____________________________________

Post Code ________State______Occupation:___________________________ Telephone (H) _________________(M)__________________

☐ **Driver** ☐ **Official** ☐ **Mechanic** ☐ **Other (Please describe)**______________________

Please tick appropriate box

C. THE INJURY

1. What is the injury you sustained? ____

2. Which part/s of your body were injured? ____

3. Describe **fully** how the injury occurred: ____

____

4. Full address of the place at which you were injured?

____

5. Were you working, or at work, or travelling to or from work at the time of the injury? ____

6. What activity were you actually engaged in at the time you were injured? ____

____

7. When did the injury occur? TIME ____________AM/PM DATE________/________/________ WEEKDAY_______________________

8. Please nominate the name(s) and address(s) of any witnesses to your accident.

Name _________________________ Address____Ph:_________________________

10. Have you **EVER** previously sustained an injury to that part of your body for which you are now making this claim? _______________________

11. If you answered "yes" to question 10 please tell us where you were when it happened, the date and how it occurred?

(Location)____ (Date) ________/________/_______ (How it occurred) ___________________

____

12. Which doctor, hospital or medical centre, if any, did you consult on the previous occasion you were injured ?

I previously attended ____for injury to this part of my body on _________/________/________

13. Was the activity in which you were engaged, at the time you injured yourself, an activity which was sanctioned and scheduled by the insured organisation? ____

14. Are you claiming or entitled to claim any benefits from any other source for this injury including Workers Compensation?

Yes ☐ If Yes, which Company/Agency?____No ☐

D. DETAILS OF YOUR CLAIM WITH YOUR HEALTH INSURER

What is the name of your private health fund?__________________________________ Membership No:________________________________

Branch location ? ________________________________ Have you made a claim yet? ______________

SECTION 1 CLAIMANT CERTIFICATION – CONTINUED

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM

E. MEDICAL DETAILS

1. When did you **first** see a doctor for the injury and who was the doctor you first saw?

The first doctor I saw was ____ on ________/_______/_______

2. Were you admitted to hospital?____________ If admitted, which hospital were you admitted to? ________________________________

3. On what date were you admitted to hospital? ________/_______/_______ On what date were you released ________/_______/_______

4. Is the doctor that you have been seeing for your injury your usual treating doctor? ___________ If not, how long have you been seeing this current doctor? ____

5. Who is your usual treating doctor and what is the address of their practice? ____

____

F. MEDICAL EXPENSES BEING CLAIMED (Complete only if you are claiming for re-imbursement of *non medicare* medical expenses)

If you are claiming for medical expenses please provide details of the expenses you are claiming reimbursement for and attach original receipts.

Date	Treatment	Provider	Cost	Account Paid ?

NOTE

IF YOU HAVE NOT MADE A CLAIM WITH YOUR PRIVATE HEALTH INSURER, *YOU MUST DO SO BEFORE* SUBMITTING THIS CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES

G. LOSS OF INCOME BEING CLAIMED – (Complete this section only if you are claiming for loss of income)

1) – SELF EMPLOYED - If YOU are self employed you must complete this Section

1. In what occupation did you work in the 12 month period before your injury (if more than one please advise and dates commenced) ?

____

2. How many hours per week did you work before your injury? ____

3. What were your duties? ____

6. Did the injury cause you to fully cease work? _____________ If so, on what date did you fully cease work? ______/______/______

7. For how long were you fully off work due to the injury? ____

8. On what date did you first return to work? ______/______/______

9. If you have not yet returned to work, when do you expect that you will return to work? ______________________________

2) EMPLOYEE - If YOU are an employee, contractor or sub contractor then your employer or principal contract MUST complete this section

I hereby certify that ____ has been engaged/employed by the company/business in the position of ________________________ since ________/_________/_______

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Did the person **ENTIRELY CEASE WORK** in their employment position?	( )	( )	______/______/______	______/______/______
Did the person **ONLY PARTIALLY CEASE WORK** in their employment position?	( )	( )	_____/______/______	______/______/______
Has the person now returned to **FULL TIME** duties?	( )	( )	______/______/______	/ __/______
Has the person now returned to **PARTIAL** duties?	( )	( )	______/______/______	_/______/______

Are there light or partial duties available within the company/business in which the person can work?______________________

If so, please state what duties are available and what hours the person could be alternately engaged by the company/business____

did he/she receive any of the following: -

from _____/_____/_____ to _____/_____/_____ in the amount of $_________ per week

( ) Paid sick leave from _____/_____/_____ to _____/_____/_____ in the amount of $_________ per week

( ) Paid holiday pay from _____/_____/_____ to _____/_____/_____ in the amount of $_________ per week

( ) Workers compensation from _____/_____/_____ to _____/_____/_____ in the amount of $_________ per week

Other (please specify) ______________________

From _____/_____/_____ to _____/_____/_____ in the amount of $__________ per week

Your name: ________________________________ Your role: ____

(Supervisor/paymaster/human resources)

Company/business name and address:____

____ Telephone No: _______________Fax No:______________

Signed____ Dated__________________

IMPORTANT !

IF YOU ARE CLAIMING FOR LOSS OF INCOME YOU MUST ATTACH PROOF OF YOUR INCOME FOR THE FULL TWELVE MONTHS BEFORE YOUR DATE OF INJURY

Acceptable proof of income is a full copy of your taxation return and assessment or a PAYG summary from your employer for the twelve month period prior to the date of the injury.

SECTION 1 - CLAIMANT CERTIFICATION – CONTINUED

THIS PAGE OF THE CLAIM FORM MUST BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM

H. DECLARATION AND INFORMATION AUTHORITIES

I understand that AFA Pty Ltd may need to access, collect and disclose information about me in order to be able to assess my claim for benefits. In order to do so, I (insert your full name here) ____of

(your address) ____

hereby authorize AFA Pty Ltd to collect and disclose information about me from and to any health insurance provider, any hospital, physician, medical practice, any medical services provider, any medical therapy provider, investigators, insurance reference bureau, 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, copies of accounts. I also agree to allow access to records relating to my injury created or held by the association, university or institution at which I sustained my injury.

In providing or obtaining information about me, I understand that AFA Pty Ltd will use that information in the assessment of my claim, and that If I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd.

AFA Pty Ltd may also collect and disclose information about me to:-

- It's relevant staff and contractors and confidential service vendors involved in delivering services on behalf of AFA Pty Ltd/Australian Family Assurance Ltd.
- An agent or broker who collects the claim form from me, or who otherwise assists in facilitating the assessment of my claim
- It's re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- It's legal service providers such as legal firms, or to accountants, actuaries, providers of medico-legal services, loss adjusters, auditors, Insurance Enquiries and Complaints Ltd (IEC Ltd) and claims management consultants.

By completing and returning this form to AFA Pty Ltd, I agree to AFA Pty Ltd collecting additional information from the parties specified above in connection with the assessment of my claim and agree to AFA Pty Ltd using and disclosing my information as set out above.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I 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. The expenses which I have claimed relate solely to the injury I sustained which is the subject of this claim. I agree that if I have 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.

Signed____ Dated _________/________/_______

Signature of Parent or Guardian if claimant under 18 years old __________________________________ Dated _________/________/_______

SECTION 2 MEDICAL CERTIFICATION

THIS PART OF THE CLAIM FORM MUST BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER WHO IS CERTIFYING THAT THE INJURED PERSON IS, OR WAS, INJURED AND/OR DISABLED FROM WORKING/OR NEEDED MEDICAL CARE.

PLEASE NOTE THAT ANY FEE INCURRED FOR THE COMPLETION OF THIS MEDICAL CERTIFICATION FORM IS THE RESPONSIBILITY OF THE PATIENT

PATIENT'S DETAILS

Patient's name:____ Date of birth: ________/________/________

1. How long has the patient been known at your practice? ______________________________ years

2. Are you the patient's primary treating physician at your practice? __________________________

3. What do you understand the patient's occupation to be?____

4. What is the medical diagnosis that is disabling the patient? ____

____

5. When did the patient **firs**t consult you in regard to this period of disability? ________/________/________

6**.** Is there any previous history of this or of a similar injury? ________________________ If so, please provide full details of the dates and the nature of the previous history of injury ____

____

7. If the patient sustained an injury, what were the circumstances of the injury?

____

8. On what date did the injury/accident occur? ________/________/________

SPECIFICS OF DISABILITY

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Has the patient been **ENTIRELY PREVENTED** from engaging in their occupation by the medical condition?	( )	( )	______/______/______	______/______/______
Has the patient **ONLY BEEN PARTIALLY PREVENTED** from engaging in their occupation?	( )	( )	______/______/______	______/______/______
Is the patient now capable of a return to **FULL TIME** duties?	( )	( )	______/______/______	
Is the patient now capable of a return to **PARTIAL DUTIES**?	( )	( )	______/______/______	

1. If the patient is not yet capable of returning to work, what is currently preventing them from doing so?__________________________________

____

2. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis

TEST	CONDUCTED ON	CONDUCTED BY	RESULT
______________________	_____/_____/_____	_________________________	____________________________________
______________________	_____/_____/_____	_________________________	____________________________________

9. What is the current regime of medical treatment given or required? (medication, therapies, surgery etc)

____

____

DOCTOR'S DECLARATION

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signed____ Dated ______/______/______

Name:____ Qualifications____

Address____ Telephone No: _________________________

SECTION 3 - SPEEDWAY AUSTRALIA CERTIFICATION

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY A SPEEDWAY AUSTRALIA ADMINISTRATION OFFICER

1. Name of Injured Person ____was injured as stated whilst participating in_________ Event at the __________________________________Speedway.

2. Name of Club?____State _________

3. Address of Club? ____

4. On what date did the Licence Holder of the insured organisation sustain the injury? _______/________/_________

5. Was the activity in which the Licence Holder of the organisation was participating; at the time of injury, an officially authorised and sanctioned activity of the insured organisation? ____

6. What is the injured person's Licence Holder number? ____

7. Was the injured person a fully financial Licence Holder of the insured organisation at the date of injury? _________________________

Declaration: I, _______________________________________ am the ____
(full name) (title of office bearer)

of the National Association of Speedway Racing Pty Ltd trading as Speedway Australia declare that the information provided in this certification is true, correct and completed to the best of my knowledge and ability.

Signed____ Dated:_______________________

NOTE:

THE OFFICER OF THE ORGANISATION WHO COMPLETES THIS PAGE OF THE CLAIM FORM <u>MUST ATTACH</u> DOCUMENTARY PROOF THAT THE INJURED PERSON WAS A CURRENT AND FINANCIAL LICENCE HOLDER OF THE INSURED ORGANISATION AT THE DATE THE LICENCE HOLDER WAS INJURED.