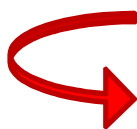




PERSONAL INJURY CLAIM FORM

For Injuries incurred after 1 February 2023



Completed claim forms must be sent to;

N2N Claims Solutions

Locked Bag 3111

Rhodes, NSW 2138

Phone: 1800 999 626

Email: sports@n2nclaims.com.au



V-INSURANCE
GROUP

INSURANCE BROKER FOR NETBALL AUSTRALIA;

Authorised Representative No. 432898 a corporate
authorised representative of Willis Towers Watson AFSL: 240600

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

Email: netball@vinsurancegroup.com

NETBALL AUSTRALIA SUMMARY OF INSURANCE COVER

What is Covered?

The Netball Australia National Risk Protection Insurance Personal Accident Insurance Program, which extends to cover Netball ACT, Netball NSW, Netball NT, Netball QLD, Netball SA, Netball TAS, Netball VIC and Netball WA, provides cover for a number of policy benefits. Please refer to the V-Insurance Group Netball Australia website to view the Product Disclosure Statement with full terms and conditions.

The most commonly claimed sections of the Netball Australia Personal Accident policy are reimbursement of Non Medicare Medical expenses and Loss of Income cover.

Important Information

The Health Insurance Act (Cth) 1973 is Federal Government Legislation which does not permit the insurer to contribute to any charges covered, or partially covered by Medicare. Sometimes, your Doctor, specialist or surgeon may charge more than the Medicare rebate, which may leave you with out of pocket expenses. This is commonly called the "Medicare Gap". The Medicare Gap is not covered by the Netball Australia Insurance Program due to Government Legislation.

Please refer to the table below for some common examples:

Non-Medicare Medical Items; claimable as per the Personal Accident policy wording	Items covered by Medicare; not claimable through the Personal Accident Policy
Ambulance	Doctor
Physiotherapist	Public Hospitals
Dental	Surgeon & Surgeon's Assistant
Private Hospital Accommodation	X-Rays
Chiropractor	Anaesthetist
MRI Scans*	MRI Scans*
*MRI scans are generally covered through Medicare; however please check with your treating physician, as sometimes the provider is not registered with Medicare.	

What are the Policy Benefits for Non Medicare Medical and Loss of Income

The following table outlines the policy benefits applicable for Non Medicare Medical and Loss of Income under the Netball Australia Insurance Program;

Non-Medicare Medical	Benefit
	Reimbursement of 75% up to \$2,500 per injury for members / players (\$5,000 for officials and volunteers) 100% cover for ambulance only up to \$2,500 for members / players and \$5,000 for officials and volunteers \$75 excess will apply if you do not have Private Health Insurance for the expense claimed. Nil excess will apply if you have claimed any portion of the cost through your Private Health fund.
Loss of Income	Benefit
If as a result of your injury you are prevented from working in your occupation a Loss of Income benefit may apply	85% reimbursement up to a maximum of \$250 per week (except Netball WA which is \$300 per week) (members / players). Higher limits apply for officials / volunteers. 14 day excess, 104 week benefit period

Important Notes

Please note: This claim form is only to be completed if your injury has occurred after 1 February 2023. If your injury occurred prior to this date please contact V-Insurance Group for the correct claim form.

This insurance cover is underwritten by: Canopus Australia & Pacific, Australia Branch
ABN 16 782 552 577

Claims are managed by: N2N Claims Solutions
ABN 60 603109 888

1. This summary of cover provides factual information about the Netball Australia Insurance Program.
2. This information is only a summary of the cover provided. The policy with full conditions is available at www.vinsurancegroup.com/netball or available by contacting Netball Australia.
3. This insurance program commences on 1 February 2023 and expires on 1 February 2024.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Netball Australia who, through injury or accident, incur financial loss and who would otherwise not have 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. Netball Australia is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

HOW TO MAKE A CLAIM

Dear Netball Australia member,

A Personal Accident Claim Form (**Claim Form**) is attached at page 5. Before lodging the Claim Form, please ensure all sections are fully completed. Failure to complete all sections of the Claim 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 5 & 6 and sign and date the Declaration.
3. Please ensure that your Association/Club official completes and signs the Association/Club Declaration on page 5.
4. If you intend to claim for Loss of Income:
 - a) You and your employer/salary office must complete page 8. If self-employed your accountant must complete these details;
 - b) You **must** complete the Tax File Declaration form on page 9. If you are employed and pay tax on the income you earn (known as PAYE), the Australian Tax Office (**ATO**) requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be forwarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.
 - c) Have your Attending Physician or Physiotherapist complete the page titled "Doctor's Statement" on page 11.
5. For claims involving Non-Medicare medical expenses:
 - a) Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).
 - b) Have your Attending Physician complete the "Attending Physician" statement on page 11.
6. 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.

7. Once you have fully completed all sections of the Claim Form, please have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.
8. Please forward the entire form with supporting documentation to N2N Claim Solutions. They handle all claims for the insurer. Their contact details are as follows;

N2N Claims Solutions
Locked Bag 3111
RHODES NSW 2138
Phone 1800 999 626
Email sports@n2nclaims.com.au

9. Your reimbursement payment will be made by N2N Claim Solutions by direct deposit.
10. Once your claim is registered, you can submit ongoing invoices via N2N Claim Solutions. N2N Claim Solutions can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.
11. If you have any further queries relating to your claim or the cover, please do not hesitate to call the V-Insurance Group Team on (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Association Name(compulsory):	Member No (if applicable):	Claimant's Given Name:	
Club Name (if applicable):		Surname:	
Name of team/age group/grade:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other	Occupation:	Date of Birth: / /	
Address	State	Postcode	Email:
Phone Number (work): ()	Home: ()	Mobile:	
Please tick the category applicable <input type="checkbox"/> Player <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Umpire <input type="checkbox"/> Other If Other, please advise _____			

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 Canopus Australia & Pacific 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 Canopus Australia & Pacific and their service providers in order to assess the claim. Canopus Australia & Pacific complies with the obligations of the Privacy Act 1998 (Cth) 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)

DECLARATION BY ASSOCIATION/CLUB

Name of Association/Club:	Name of Association/Club Official making this statement:	
Official Position:	Telephone Number: () Email:	
Address	State	Postcode
I, the above mentioned Netball Australia Club Official, confirm that the claimant was a registered and Financial member of this Netball Australia Club and was an insured person as identified in the Personal Accident Insurance with Canopus Australia & Pacific at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.		
Do you have any comments in relation to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please detail below _____		
Dated: / /	Signature of Association/Club Official:	

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	<input type="checkbox"/>
	Officially organised training	<input type="checkbox"/>
	Social or private competition	<input type="checkbox"/>
	Travelling to and from activity	<input type="checkbox"/>
	Sanctioned fundraising/social event	<input type="checkbox"/>

What type of Netball activity were you participating in? (please tick)	Netball Association / Club Activity	<input type="checkbox"/>
	Fast 5 Netball	<input type="checkbox"/>
	NetFest	<input type="checkbox"/>
	Social Netball Training / Competition	<input type="checkbox"/>

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? Yes/No	If yes, please advise when? / /
---	---------------------------------------

The following information is required for Netball Australia research to assist with Risk Management, answering these questions will not affect your claim

Where did your injury occur? (please tick)	Indoor	<input type="checkbox"/>
	Outdoor	<input type="checkbox"/>
Surface at point of injury? (please tick)	Timber	<input type="checkbox"/>
	Synthetic	<input type="checkbox"/>
	Concrete / Asphalt	<input type="checkbox"/>
	Other, please advise.....	<input type="checkbox"/>
Weather conditions? (please tick)	Fine	<input type="checkbox"/>
	Rain	<input type="checkbox"/>
	Showers	<input type="checkbox"/>
	Extreme Heat	<input type="checkbox"/>
	Extreme Cold	<input type="checkbox"/>
Surface Conditions? (please tick)	Wet	<input type="checkbox"/>
	Dry	<input type="checkbox"/>
	Other, please advise.....	<input type="checkbox"/>
Quarter/half injured? (please tick)	1 st Quarter	<input type="checkbox"/>
	2 nd Quarter	<input type="checkbox"/>
	3 rd Quarter	<input type="checkbox"/>
	4 th Quarter	<input type="checkbox"/>
	Not applicable	<input type="checkbox"/>

LOSS OF INCOME

YOU MUST COMPLETE THIS SECTION & THE TAX FILE NUMBER DECLARATION FORM IF YOU ARE CLAIMING FOR LOSS OF INCOME

(please tick Yes No)

1. Can compensation be claimed under worker's 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: Net \$..... Gross \$..... <small>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.</small>	Date commenced employment with company: / /	

Income Definition:

Self Employed Full Time Part Time

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:	Date: / /
Company Stamp:	ABN/ACN:

B. IF SELF EMPLOYED

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



Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
- Print X in the appropriate boxes.
- Read all the instructions including the privacy statement before you complete this declaration.

Section A: To be completed by the PAYEE

1 What is your tax file number (TFN)?

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN.

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax.

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance.

2 What is your name?

Title: Mr Mrs Miss Ms

Surname or family name

First given name

Other given names

3 What is your home address in Australia?

Suburb/town/locality

State/territory

Postcode

4 If you have changed your name since you last dealt with the ATO, provide your previous family name.

5 What is your primary e-mail address?

6 What is your date of birth?

Day / Month / Year

7 On what basis are you paid? (select only one)

Full-time employment Part-time employment Labour hire Superannuation or annuity income stream Casual employment

8 Are you: (select only one)

An Australian resident for tax purposes A foreign resident for tax purposes OR A working holiday maker

9 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Yes No Answer no here if you are a foreign resident or working holiday maker, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

10 Do you have a Higher Education Loan Program (HELP), VET Student Loan (VSL), Financial Supplement (FS), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes No Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment.

DECLARATION by payee: I declare that the information I have given is true and correct.

Signature

Date Day / Month / Year

You MUST SIGN here

There are penalties for deliberately making a false or misleading statement.

Once section A is completed and signed, give it to your payer to complete section B.

Section B: To be completed by the PAYER (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number?

Branch number (if applicable)

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes No

3 What is your legal name or registered business name (or your individual name if not in business)?

4 What is your business address?

Suburb/town/locality

State/territory

Postcode

5 What is your primary e-mail address?

6 Who is your contact person?

Business phone number

7 If you no longer make payments to this payee, print X in this box.

DECLARATION by payer: I declare that the information I have given is true and correct.

Signature of payer

Date Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Return the completed original ATO copy to:

Australian Taxation Office
PO Box 9004
PENRITH NSW 2740

IMPORTANT

See next page for:
■ payer obligations
■ lodging online.



Completed claim forms should be sent to N2N Claims Solutions
sports@n2nclaims.com.au or Locked Bag 3111, Rhodes NSW
 2138 For any inquiries please call the Insurance Broker for this
 policy, V-Insurance Group on 1300 945 547

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.
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/PHYSIOTHERAPIST

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? / /

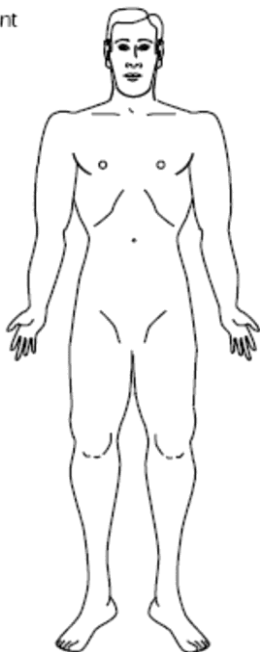
Patient's Occupation:

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

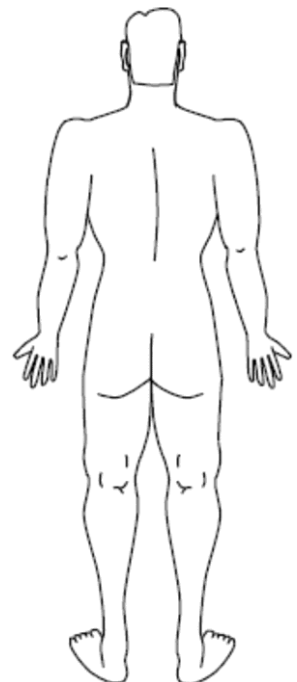
If not, please advise who is

What is the exact nature of the present injury?

Front



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 netball?

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, you will be able to receive your payment only by Electronic Funds Transfer (EFT) to a nominated bank account

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 BY CLAIMANT (OR GUARDIAN IF CLAIMANT UNDER 18)

I understand that by investigating my claim or by accepting proof of my claim, neither N2N Claims Solutions (**N2N**) or Canopius Australia & Pacific (**Canopius**) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to N2N or Canopius using and disclosing my personal information pursuant to their Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to N2N's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to N2N or Canopius such personal information (including health information) as N2N or Canopius in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to N2N in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, N2N or Canopius may not be able to process or assess my claim.

I appoint N2N to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature: _____

Date: _____

Print Name: _____

PRIVACY NOTICE

Canopius Australia & Pacific (Canopius) and N2N Claims Solutions (N2N) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Canopius and N2N.

Canopius collects personal information in order to provide insurance services and products and for ancillary business purposes and N2N collects personal information in order to provide claim assessments and insurance related services. Canopius and N2N may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in London.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Canopius and N2N. If you do not provide the personal information Canopius, N2N or other relevant third parties require to offer you specific products or services, Canopius or N2N may not be able to provide the appropriate type or level of service.

When you give Canopius or N2N personal or sensitive information about other individuals, Canopius and N2N rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

MEDICAL AUTHORITY

By executing the declaration I consent to N2N or Canopius using and disclosing my personal and any sensitive information obtained through this document and for the purpose of assessing my claim including any entitlement to benefits under the policy, or the health and safety evaluation of the sport of Netball, including disclosing such information to Netball Australia (including any subsidiary bodies) and Netball Australia's insurance agent pursuant to their Privacy Policies.

I authorise any person or entity, including any hospital and / or physician who has treated me, to provide to N2N or Canopius such personal or sensitive information (including medical records, my past medical history or other health information) as N2N or Canopius in their absolute discretion consider necessary for their assessment of my claim or my entitlement to benefits.