Who should use this claim form?

You should complete this form if:

**Insured** - You are a registered member, official or volunteer (Insured Person) of a Club (the Insured) covered within the Bushwalking Australia Risk Protection Programme

☑️ ; and

☑️ **Injured** - You sustained an accidental injury during the Policy Period whilst actually participating in a sanctioned bushwalking event/activity; and

☑️ **Non-Medicare** - You are likely to incur or have incurred medical costs that are not listed on the Medicare Benefits Scheme

Before completing this form, ensure you are familiar with the Product Disclosure Statement (PDS) available on the insurance section of Bushwalking Australia’s website [www.bushwalkingaustralia.org/insurance](http://www.bushwalkingaustralia.org/insurance)

What is covered?

The Bushwalking Australia Risk Protection Programme’s Personal Accident cover provides some reimbursement for Non-Medicare Medical Costs and/or Loss of Income cover for 12 months from the date of injury.

Commonwealth Legislation prevents reimbursement of Medicare costs including the Gap. Non-Medicare Medical Benefits are covered up to the limits outlined below.

Please refer to [www.bushwalkingaustralia.org/insurance](http://www.bushwalkingaustralia.org/insurance) for the Product Disclosure Statement (PDS).

How much can I claim?

Please refer to the Programme Summary available on the Bushwalking Australia website for details about how much you can claim – [www.bushwalkingaustralia.org/insurance](http://www.bushwalkingaustralia.org/insurance)

What is NOT covered?

The following examples demonstrate some areas not covered by the Personal Accident cover:

☑️ Medicare items (see below);
☑️ the Medicare Gap (see below);
☑️ Injuries sustained whilst playing against medical advice.

Please refer to [www.bushwalkingaustralia.org/insurance](http://www.bushwalkingaustralia.org/insurance) for the Product Disclosure Statement (PDS) for further details.

What does “Non-Medicare” mean?

Medicare is a Commonwealth Government programme that provides free or subsidised treatment from medical professionals such as doctors and specialists. The Medicare Benefits Scheme (MBS) lists the items that are eligible for a Medicare rebate.

Sometimes, your doctor or specialist may charge more than the Medicare rebate, which may leave you with out-of-pocket expenses. This is commonly called the “Medicare Gap”.

Section 126 of The Health Insurance Act 1973 (Cth) does not permit the Insurer or the JLT Trustee to reimburse any part of a Medicare item (this includes the Medicare Gap).

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the Bushwalking National Risk Protection Programme. For further information about Medicare please visit [www.health.gov.au](http://www.health.gov.au) or [www.medicare.gov.au](http://www.medicare.gov.au)

Please note: Some Private Health Funds may offer Medicare Gap Insurance Cover. JLT Sport is not a Private Health Fund, nor do we offer Private Health Insurance.
How to lodge a Personal Injury Claim:

1. Complete ALL sections of the Personal Injury Claim Form
   - Your claim form may be returned if there is important information missing
   - For assistance, please contact Accident & Health International (AHI) on +61 2 9251 8700

2. Send your completed claim form to AHI Claims Department – GPO Box 4213, Sydney, NSW, 2001 or claims@acchealth.com.au within 120 days from the date of injury
   - Do not wait until your treatments have concluded before you lodge your claim
   - You can lodge your claim even if you have no out of pocket expenses

3. AHI will confirm receipt of your claim and provide you with a claim number, or contact you should they require further information

4. Once you have received your Claim Number, you can forward further Non-Medicare Medical receipts to AHI as your treatment continues (for up to 12 months from the date of injury).

What should I send with my claim?

Receipts - If you have already undertaken treatments for your injury and incurred Non-Medicare Medical costs please submit your receipts to AHI.

Retain a copy - Please submit only original receipts to AHI. We recommend you retain a copy of all receipts and your Claim Form for your records.

Private Health Insurance (if applicable) – Please claim through your Private Health Fund first and then send AHI a copy of your Private Health rebate advice.

Claims Conditions:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to AHI within 120 days from the date of injury.

Subject to the Insurance Contracts Act 1984, any treatment must be completed within 12 calendar months from the date of injury.

All certificates and evidence required by AHI must be provided by you upon request and at your expense (if applicable).

Who is Accident and Health International (AHI)?

AHI administers the Personal Accident Policy for the Bushwalking Australia Risk Protection Programme (arranged by JLT Sport). AHI manages all claims associated with this policy.

Who is JLT Sport?

JLT Sport is the appointed broker for the Bushwalking Australia Risk Protection Programme. As a division of Jardine Lloyd Thompson Pty Ltd, JLT Sport is Australia’s leading provider of insurance and risk protection for the sport, recreation and fitness industries.
Section A: Claimant's Details

PERSONAL INFORMATION:

Claimant's Name: ____________________________  ____________________________

First Name  Surname

Postal Address: ____________________________  ____________________________  ____________________________  ____________________________

Street Address  State  Postcode

Contact Details:

Email Address  Phone Number (Bus. Hours)

Personal Details:  / /  ☐ Male  ☐ Female  / /  AM PM

Date of Birth  Gender  Date of Injury  Time of Injury

Club Name: ____________________________

Describe your injury and how it happened (please attached additional pages if required):

INJURY RESEARCH DATA:

Weather Conditions:  ☐ Fine  ☐ Rain  ☐ Extreme Heat  ☐ Extreme Cold

Activities:  ☐ Liloing  ☐ Cycling  ☐ Orienteering  ☐ Bushwalking – day walk

☐ Rafting  ☐ Boating  ☐ Rogaining  ☐ Bushwalking – pack carry

☐ Caving  ☐ Training  ☐ Swimming  ☐ Social Activities

☐ Canoeing  ☐ Kayaking  ☐ Snow Skiing  ☐ Club Meetings

☐ Abselling  ☐ Canyoning  ☐ Rock Scouring  ☐ Track Hut Construction / Maintenance

Resumption date(s):  / /  N/A  N/A

When will you resume WORK?  N/A  N/A

Private Health Cover:  ☐ Yes  ☐ No

Do you have Private Health Insurance?  If YES, what is the name of your Private Health Insurance Provider?

Private Health Coverage:

☐ Dental  ☐ Physiotherapy  ☐ Ambulance  ☐ Hospital

Ambulance Membership:  ☐ Yes  ☐ No

PAYMENT DETAILS:

EFT Payee Details:

Bank  Name on Account  BSB  Account Number

CLAIMANT DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. The injury was sustained accidentally during a bushwalking activity and is not a pre-existing illness or condition.

B. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.bushwalkingaustralia.org/insurance.

C. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing costs that are registered with Medicare (including the Medicare Gap).

D. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer and the Claims Managers.

E. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish Sportscover’s representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatments, copies of all hospital or medical records and copies of employment records.

F. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

G. You declare that the forgoing particulars are true and accurate in every detail. You agree that if you have made, or shall make, in any further declaration regarding this injury, any false or fraudulent statements or suppress or conceal or falsely state any material whatsoever, the covers shall be void and all rights to recover there under for past or future injuries shall be forfeited.

Claimant’s Signature*  ____________________________

Date:  / /  

*Parent or Guardian if under 18 years
### Section B: Club Declaration

#### CLUB DETAILS:

<table>
<thead>
<tr>
<th>Claimant’s Name:</th>
<th>First Name</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Club Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Club Contact:</td>
<td>Club Contact Person</td>
<td>Position within Club</td>
</tr>
<tr>
<td>Contact Details:</td>
<td>Contact Phone Number</td>
<td>Email Address</td>
</tr>
<tr>
<td>N/A:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### INJURY DETAILS:

| Date/Time: | / / | AM PM |
| N/A:       |     |       |
| N/A:       |     |       |

Location:

Where did the injury occur?

| N/A:       |     |       |
| N/A:       |     |       |

#### CLUB DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are an authorised representative of, and you are acting on behalf of, the Claimant’s Club or League (as above).
B. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
C. You declare the Claimant’s injury was sustained accidentally during the bushwalking activity noted above and is not a pre-existing illness or condition.

Club Representative’s Signature: ____________________________ Date: / / 

#### WITNESS STATEMENT:

A Statement from anyone who has witnessed your accident is required. Please have a witness provide a full description of the incident giving rise to the claimant’s injury, as seen by the witness:

<table>
<thead>
<tr>
<th>Witness’s Name:</th>
<th>Witness’s Address:</th>
<th>Official’s Signature:</th>
<th>Date: / /</th>
</tr>
</thead>
</table>

Send completed forms to:

AHI Claims Department
GPO Box 4213, Sydney, NSW, 2001
Email: claims@acchealth.com.au
Claims Enquiries:
Phone: 02 9251 8700

www.jltsport.com.au
Section C: Loss of Income

TO BE COMPLETED BY THE CLAIMANT:

Do you wish to claim Loss of Income Benefits?  
[ ] Yes  [ ] No  If NO, proceed to SECTION D

If you are NOT claiming Loss of Income Benefits please do not complete this section. Please proceed to Section D.

Can you claim compensation from any other policy that includes loss of income benefits (such as Workers Compensation)?  
[ ] Yes  [ ] No

Have you ever made previous claims in respect to a personal accident insurance policy or plan?  
[ ] Yes  [ ] No

Have you engaged in any other income earning employment since you became injured?  
[ ] Yes  [ ] No

TO BE COMPLETED BY THE CLAIMANT’S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED):

Claimant’s Name:  
First Name  Surname

Employer/Business:  
Employer/Company Name  Contact Person

Postal Address:  
Street Address  State  Postcode

Contact Details:  
Email Address  Phone (Bus. Hours)  Mobile

Employment Status:  
[ ] Full Time  [ ] Part Time  [ ] Casual  [ ] Self Employed

Employment Details:  
Employee's NET weekly salary  Employee's GROSS week salary  Date Employee commenced with company.

Injury Details:  
Date employee ceased work  Date expected to resume duties

Returned to Work:  
[ ] Yes  [ ] No  If YES, what date did the Employee return?

Salary Received:  
[ ] Yes  [ ] No  If YES, what for?

Sick Leave:  
[ ] Yes  [ ] No  from  /  /  to  /  /

Annual Leave:  
[ ] Yes  [ ] No  from  /  /  to  /  /

Other:  
[ ] Yes  [ ] No  from  /  /  to  /  /

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived from playing sport.

EMPLOYER’S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You are the Claimant's current employer (or accountant if the claimant is self-employed),
B. After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,
C. You will supply upon request any further information as required for the determination of this claim.

Employer’s Signature:  
Date:  /  /
Section D: Physician’s Report

This section must be completed (in full) by your attending physician.
An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT

**Physician’s Report**

<table>
<thead>
<tr>
<th>Claimant’s Name:</th>
<th>First Name</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Details:</td>
<td>Physician’s Name</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injury Consultation:</th>
<th>/</th>
<th>/</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Injury</td>
<td>Date of Consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis/History of injury:

Injury Location:
- □ Ankle
- □ Arm
- □ Dental
- □ Facial
- □ Foot
- □ Hand
- □ Head
- □ Internal
- □ Knee
- □ Lower Leg
- □ Shoulder
- □ Spinal
- □ Torso
- □ Upper Leg

Please mark (✓) the anatomical location below:

Injury Type:
- □ Amputation
- □ Bruising
- □ Concussion
- □ Cut
- □ Death
- □ Dental
- □ Dislocation
- □ Fracture/Break
- □ Rupture
- □ Sprain
- □ Strain
- □ Fatigue/Debilitation

First Medical Treatment:

<table>
<thead>
<tr>
<th>Date of Treatment</th>
<th>Name of attending physician</th>
</tr>
</thead>
</table>

Do you consider the Claimant’s injury to be a NEW injury?
- □ Yes
- □ No

Do you consider the Claimant’s injury to a recurrence of a previous injury?
- □ Yes
- □ No

If YES, please provide details and a description:

Does the Claimant have any congenital defects or chronic diseases?
- □ Yes
- □ No

If YES, please provide details and a description (dates, name of treating doctor, etc):

Please continue to Page 7.
Section D: Physician’s Report

PHYSICIAN’S REPORT (continued)

Have you referred the patient to any other services or treatment?

☐ Yes ☐ No

If YES, please provide details below:

Physiotherapy: ☐ Yes ☐ No

☐ Yes ☐ No

If YES, approx. number of treatments required.

Chiropractics: ☐ Yes ☐ No

☐ Yes ☐ No

If YES, approx. number of treatments required.

Surgery: ☐ Yes ☐ No

☐ Yes ☐ No

If YES, please provide details.

Other: ☐ Yes ☐ No

☐ Yes ☐ No

If YES, please provide details.

Has the Claimant been able to do any work since the injury occurred?

☐ Yes ☐ No

What date do you advise the Claimant to return to Bushwalking?

/ / 

PHYSICIAN’S DECLARATION:

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant’s injury as described on this form;
B. You declare that all information provided by you and supplied herein is true and accurate.

Physician’s Signature: ____________________________  Date: / / 

LOSS OF INCOME CLAIMS ONLY

The following Incapacity to Work Statement must be completed by a qualified Medical Practitioner (i.e. General Practitioner, Surgeon or a Specialist). It will not be accepted if completed by a Physiotherapist, Chiropractor, etc.

INCAPACITY TO WORK STATEMENT:

I, ______________________________________, examined ____________________________ on / /

Medical Practitioner’s Name  Claimant’s Name  Date of examination

In my opinion, this person is/has been unfit to work from / / to / / inclusive.

First day of incapacity  Last day of incapacity

Please provide any further comments in regard to your assessment of the injury/condition?

By signing the declaration below, you confirm and agree to the following:

A. You have examined the Claimant’s injury as described on this form;
B. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner’s Signature: ____________________________  Date: / /