JLT SPORT PERSONAL INJURY CLAIM FORM

AUSTRALIAN FOOTBALL NATIONAL RISK PROTECTION PROGRAMME AFL 9'S

WHO SHOULD USE THIS CLAIM FORM?

You should complete this form if:

- Insured: You are a participant of an AFL 9's Team insured within the AFL National Risk Protection Programme; and
- Injured: You sustained an accidental injury during the Policy Period whilst actually participating in an AFL 9's 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 JLT Sport's web site www.jltsport.com.au/afl

WHAT IS COVERED?

The AFL National 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.

Loss of Income Cover is not automatically provided. If you are considering a Loss of Income claim, please check that your club has purchased Loss of Income cover before completing Section C. Please note - claimants must exhaust all of their sick leave benefits before being able to claim loss of income through this policy.

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

Please refer to JLT Sport's web site for the Product Disclosure Statement (PDS).

HOW MUCH CAN I CLAIM?

The following table outlines the reimbursement capacity within the AFL National Risk Protection Programme.

Non-Medicare Medical Costs	Loss of Income
80% Reimbursement	80% Reimbursement
$2,000 maximum per claim	$300 maximum per week
$100 excess per claim	14 day elimination period

All AFL 9's participants are entitled to the above coverage at the commencement of each period of cover.

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 JLT Sport's web site 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).

WHAT DOES "NON-MEDICARE" MEAN CONTINUED

This means that if your treatment is listed on the Medicare Benefits Scheme, it is not claimable through the AFL National Risk Protection Programme. For further information about Medicare please visit www.health.gov.au or 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 Echelon on 1800 640 009
2. Send your completed claim form to Echelon within 270 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. Echelon 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 Echelon 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 Echelon.

Retain a copy - Please submit only original receipts to Echelon. 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 Echelon a copy of your Private Health rebate advice.

HOW TO SEND COMPLETED FORMS

Email	sportclaims@echelonaustralia.com.au
Post	Echelon Claims Services GPO Box 1693 Adelaide SA 5001
Fax	08 8235 6107

CLAIMS CONDITIONS:

Written notice containing full particulars of your injury (as per this Claim Form) must be submitted to Echelon within 270 days from the date of injury.

Subject to the Trustee's discretion and/or 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 Echelon must be provided by you upon request and at your expense (if applicable).

WHO IS ECHELON?

Echelon Australia Pty Ltd (Echelon) is a wholly owned subsidiary of JLT. Echelon is the appointed claims management group for all Personal Injury claims on behalf of the Insurer and the Trustee of the AFL National Risk Protection Programme.

WHO IS JLT SPORT?

JLT Sport is the appointed broker for the AFL National 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

Claimant's Name:					
Postal Address:					
Occupation:					
Email Address			Phone Number		
Date of Birth			☐ MALE	☐ FEMALE	
Date of Injury		Time Of Injury		☐ AM	☐ PM
Club Name:					

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

INJURY RESEARCH DATA

Session:	☐ Playing	☐ Training	☐ Travelling	☐ Event	☐ Other	☐ Warm up/down
Location:	☐ Indoor	☐ Outdoor				
Injured Person	☐ Player	☐ Umpire	☐ Official	☐ Trainer	☐ Other (Please Specify)	
Grade:	☐ Senior	☐ Junior	☐ Not Applicable			
Surface Type:	☐ Asphalt	☐ Concrete	☐ Grass	☐ Indoor	☐ Timber	☐ Synthetic Grass
Weather Conditions:	☐ Fine	☐ Rain	☐ Extreme Heat		☐ Extreme Cold	
Surface Conditions:	☐ Wet	☐ Dry	☐ Muddy	☐ Indoor	☐ Other (Please Specify)	
Period:	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ Other (Please Specify)	
When will you resume WORK?						
When will you resume TRAINING?						
When will you resume PLAYING?						
Do you have Private Health Insurance?					☐ YES	☐ NO

INJURY RESEARCH DATA CONTINUED				
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			
Bank		Account Name	
BSB		Account Number	

CLAIMANT DECLARATION

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

1. The injury was sustained accidentally during a football activity and is not a pre-existing illness or condition.
2. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.jltsport.com.au/afl
3. 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).
4. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT, the insurer, the Trustee and the Claims Managers.
5. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish JLT'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.
6. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.
7. 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.
8. You authorise any and all information regarding claims with any other insurer to be released to JLT's representatives.

Claimant's Signature *(Parent or Guardian if under 18 years)*		Date:	

SECTION B - CLUB DETAILS				
Claimant's Name:				
Club Name:				
Club Contact:				
Position within Club:				
Email Address			Phone Number	

INJURY DETAILS						
Date of Injury			Time of Injury		☐ AM	☐ PM
Circumstances:	☐ Playing	☐ Training	☐ Travelling	☐ Other (Please Specify)		
Opposition Club Name (If Applicable)						
Ground/Location Where the Injury Occured						

INJURY DETAILS CONTINUED		
Has the Claimant returned to TRAINING?	☐ YES	☐ NO
If YES, date Claimant returned?		
Has the Claimant returned to COMPETITION?	☐ YES	☐ NO
If YES, date Claimant returned?		

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 football activity noted above and is not a pre-existing illness or condition.
D. You understand that registering your club with JLT Sport is a requirement of the AFL National Risk Protection Programme for each Period of Cover.
E. You confirm the club's level of cover as per the details provided above.

Club Representative's Signature:		Date:	

SECTION C – LOSS OF INCOME

TO BE COMPLETED BY THE CLAIMANT

Do you wish to claim Loss of Income Benefits?	☐ YES	☐ NO

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:				
Employer/Business:				
Contact Person:				
Postal Address:				
Email Address				
Phone (Bus. Hours)			Mobile	
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed

Employment Details If Self-Employed or Casual, please provide average weekly salary based on 12 month period directly prior to injury.						
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:						
Has the Employee returned to work?					☐ YES	☐ NO
If YES, what date did the Employee return?						
Salary Received:						
During the period of incapacity, has the employee received a salary?					☐ 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: * Accountant's signature (if claimant is self-employed)		Date:	

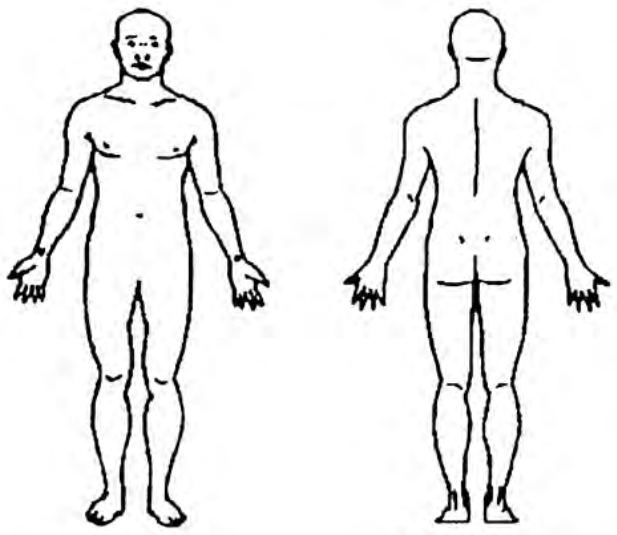
SECTION D - PHYSICIAN'S REPORT

THIS SECTION MUST BE COMPLETED WITHOUT EXPENSE TO JLT SPORT - This section must be completed (in full) by your attending physician. *An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.*

Claimant's First Name:		Claimant's Last Name:	
Physician's Name		Phone Number	
Injury Consultation:			
Date of Injury		Date of Consultation	
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:			
Name of attending physician			
Date of treatment			
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 deases?		☐ YES	☐ NO
If YES, please provide details and a description (dates, name of treating doctor, etc):			
Have you referred the patient to any other services or treatment?		☐ YES	☐ NO
If YES, please provide details below:			
Physiotherapy:		☐ YES	☐ NO
If YES, approx. number of treatments required.			
Chiropractics:		☐ YES	☐ NO
If YES, approx. number of treatments required.			
Surgery:		☐ YES	☐ NO
If YES, please provide details			
Other:		☐ YES	☐ NO
If YES, please provide details			
Has the Claimant been able to do any work since the injury occurred?		☐ YES	☐ NO
If YES, please provide details			
What date do you advise the Claimant to return to playing Football?			

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.

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 _____

(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:	

For more information, please refer to JLT Sport's web site www.jltsport.com.au/afl

JLT COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.

- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other JLT products or services and administering payments to you. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.

- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and JLT related Group companies.

- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other JLT Group companies, insurers, reinsurers and other third party service providers (e.g. data storage providers) in the United Kingdom, Singapore, Hong Kong, the United States of America and elsewhere.

- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent. We will use and disclose your personal information in accordance with our Privacy Policy.

- Our Privacy Policy can be accessed on our website (http://au.jlt.com/). For further information contact your account executive or the JLT Privacy Officer:

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