Claim Form Under University/Sporting Association

AFA INSURANCE

This is the form to use when making a claim on any policy provided by AFA Pty Ltd, AFS Licence No 247122.

Correct completion of these forms will assist us to make accurate and faster decisions regarding our customers' claim for benefits and ensure that where benefits are payable that they reach our customers
in a timely manner. Incomplete claim forms will be returned for completion, leading to assessment delays.

Please remember that premium payments are not waived when you make a claim and you must continue to pay the premium whilst you are claiming benefits

This claim form can be used for making two types of claims. You can use this form to claim for re-imbursement of medical expenses and/or you can also use this form to claim for weekly benefits due to the loss of your income where that cover eists under the policy. you should check with your member organisation whether the policy covers you for the loss of your income.

IMPORTANT NOTE

There are three sections to this claim form

Sections one, two and three must be completed in all cases.

Section one: CLAIMANT CERTIFICATION is to be completed by the person making the claim (the sick or injured person)

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 (ANY FEE INCURRED FOR COMPLETION OF THIS FORM BY THE DOCTOR IS THE RESPONSIBILITY OF THE PERSON MAKING THE CLAIM)

Section three: FINANCIAL CERTIFICATION is to be completed by an official of the insured organisation (e.g., an Associaton Secretary/Association Administration Officer/ University Member Services Officer)

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

ELECTRONIC FUNDS TRANSFER FORM (EFT) for Claim Payments

Important: Should your claim be accepted & benefits are payable we will require your account details.
Please be sure to complete the following section so that payments can be processed.

Claimant's name

Name of Bank/Credit Union:

BSB Number (6-digit number):

Account Name:

Account Number

I authorise AFA Pty Ltd and its appointed third party administrator, Fullerton Health Corporate Services to directly credit claim benefits to my account as noted above.

Signature of Claimant Authorising EFT benefits:

Date: / /

Note: Providing your account details above does not mean that your claim is acceptable and qualify you for benefits.
This form is used to initiate a claim only.

SECTION 1 Claimant Certification To be completed by the person making the claim (the injured or sick person)

Policy No

Name of University or Association

1.1 Type of Claim

Which Benefit are you claiming for?

Medical expenses ☐ Loss of income ☐

1.2 Your Details

First Name

Surmane

Date of birth ☐☐ / ☐☐ / ☐☐☐☐

Medicare Number

Full address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Address for correspondence (if different) Number and street

Suburb/town

State

Postcode

Contact number during business hours (☐☐) ☐☐☐☐ ☐☐☐☐

After hours number (☐☐) ☐☐☐☐ ☐☐☐☐

Mobile number ☐☐☐☐☐☐☐☐☐☐

Email address via email?

Do you consent to receive important information about your claim

No ☐ Yes ☐

What is your occupation?

1.3 Details of the injury .

1. What is the injury you sustained?
2. Which part/s of the body were injured?
3. Describe fully how the injury occurred:
4. Full address at which you were injured — Suburb/town — State — Postcode
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: ☐☐ / ☐☐ / ☐☐☐☐
8. Please nominate the name and address of a witness who saw you injure yourself:

Witness Name

Full address of witness — Suburb/town — State — Postcode

Contact number (☐☐) ☐☐☐☐ ☐☐☐☐

Contact number (☐☐) ☐☐☐☐ ☐☐☐☐

9. Have you EVER previously sustained an injury to that part of your body for which you are no making this claim? No ☐ Yes ☐

10. If you answered YES to question 9 please tell us where you when when it happened, the date and how it occurred?

Location

Date: ☐☐ / ☐☐ / ☐☐☐☐

How the previous injury occured

11. Which doctor, hospital or medical centre, if any, did you consult the previous time you injured this/these parts of your body?

I previously saw Doctor (their name) | for injury to this part of my body | on (the date) ☐☐ / ☐☐ / ☐☐☐☐

12. Was the activity in which you were engaged, at the time you injured youself , an activity which was sanctioned and scheduled by the insured organisation

No ☐ Yes ☐

1.4 Details of your claim with your health insurer

What is the name of your private health fund?

Membership Number

Have you made a claim yet?

No ☐ Yes ☐

What branch of your health fund do you usually deal with?

1.5 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 was was ____ on ☐☐ / ☐☐ / ☐☐☐☐

2 Were you admitted to hospital?

No ☐ Yes ☐ If admitted, which hospital were you admitted to? (please attach a copy of the hospital admission or discharge summary)

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 or sickness your usual treating doctor?

Yes ☐ No ☐ If not, how long have you been seeing this current doctor? ☐☐ days ☐☐ months ☐☐ years

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

Doctor's name

Telephone number (☐☐) ☐☐☐☐ ☐☐☐☐

Full address of practice

Suburb/town

Postcode

State ☐☐☐

Contact number (☐☐) ☐☐☐☐ ☐☐☐☐

1.6 Medical Expenses Being Claimed (complete only if you are claiming for re-imbursement of 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 re-imbursement of medical expenses

1.7 Loss of Income Being Claimed (Complete this section only if you are claiming for loss of income)

1. In what occupation did you work in the 12 month period before you injured yourself?
2. How many hours per week did you work before you injured yourself?
3. What were your duties?
4. Where you self employed or an employee?
5. Did the injury cause you to fully cease work? No ☐ Yes ☐

   If so, on what date did you fully cease work? ☐☐ / ☐☐ / ☐☐☐☐
6. For how long were you fully off work due to the injury
7. On what date did you first return to work? ☐☐ / ☐☐ / ☐☐☐☐
8. If you have not yet returned to work, when do you expect that you will return to work? ☐☐ / ☐☐ / ☐☐☐☐

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 for the twelve month period prior to the date of the injury

1.8 Declaration and Information Authorities

I understand that AFA Pty Ltd (ABN 83 067 084 33, AFS License No. 247122) and its appointed third party administrator, Fullerton Health Corporate Services 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)

Suburb/town

Postcode

State

hereby agree that I have read, understood and agree to the collection, use and disclosure of my personal information by AFA Pty Ltd and / or Fullerton Health Corporate Services as outlined in the Privacy Notice on page 12 of this document.

In addition and without limiting the above, I authorise AFA Pty Ltd and / or Fullerton Health Corporate Services to collect and disclose any information about me from and to any organisation or person including the following, (which includes their current and former capacities and any organisation or person that may replace them): Medicare, any insurance or health insurance company, other insurance intermediaries, Centrelink, any hospital, physician, medical practice, medical services provider, medical therapy provider, employer, investigators, assessors and loss adjustors, other parties we may be able to claim or recover against, insurance reference bureau, financial institutions including banks, the Australian Taxation Office and my accountant.

In providing or obtaining information about me, I understand that AFA Pty Ltd and / or Fullerton Health Corporate Services 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.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd or Fullerton Health Corporate Services, 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. I agree that if I have made any misrepresentations, false or fraudulent statements, or have concealed information of a material nature relevant to
the assessment of my claim, that subject to law, the policy may be cancelled and / or AFA Pty Ltd and / or its third party administrator, Fullerton Health Corporate Services, may refuse to pay
a claim.

Signature

Date

/ /

To be completed if another person has signed on behalf of the injured person

Name of person who signed on behalf of the injured person

Relationship to the injured person

Reason why the injured person could not sign

Section 2 Medical certification

This part of the claim form must be completed by a registered doctor who is certifying that the injured or sick person is, or was, disabled from working.

Please note that any fee incurred for the completion of this medical certification form is the responsibility of the patient.

Please note that medical certification is not accepted prior to the date you have first been consulted for this medical condition.

2.1 Patient's details

First name

Surname

Date of birth / /

Male Female

Height

Weight

Full address (Note: we do not accept post office boxes as the address) Number and street

Suburb/town

State

Postcode

1. How long has the patient been known at your practice? years
2. Are you the patient's primary treating physician at your practice?

   Yes No If not, please provide details of the physician who is

3. What do you understand the duties of the patient's occupation/business to be?
4. What is the medical diagnosis disabling the patient?
5. When did the patient first consult you in regard to this period of disability? / /
6. Was there ANY previous history of this or of a similar condition?

   No Yes If so, please provide full details of the dates and the nature of the previous history of the injury or sickness

7. If the patient sustained an injury, what were the circumstances of the injury?
8. On what date did the injury/accident occur? / /

2.2 Specifics of disability

Has the patient been ENTIRELY PREVENTED from engaging in their occupation by the medical condition?

No Yes If so, from what date / /

to what date / /

Has the patient ONLY BEEN PARTIALLY PREVENTED from engaging in their occupation by the medical condition?

No Yes If so, from what date / /

to what date / /

Is the patient now capable of return to FULL TIME DUTIES?

No Yes If so, from what date / /

Is the patient now capable of return to PARTIAL DUTIES?

No Yes If so, from what date / /

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. (Please attach copies.)

Test	Conducted On	Conducted By	Result

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

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.

Signature

Date

☐☐ / ☐☐ / ☐☐☐☐

Name

Qualifications

Practice address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Telephone number

(☐☐) ☐☐☐☐ ☐☐☐☐

Email address

Section 3 Association Certification

This section of the claim form needs to be completed by an official of the insured organisaiton (e.g. an Association Secretary/Association Administration Officer/University Member Services Office)

This official must attach documentarty proof that the injured person was a financial member of the insured organisation at the time of the injury.

1 What is the full name of the insured organisation?

Phone Number ( )

2. What is the official postal address of the insured organisation?

Suburb/town State Postcode

3. What is the full name and date of birth of the injured member?

First name Surname

Date of birth / /

4. On what date did the member of the insured organisation injure themselves? / /

5. What was the member of the organisation actually doing at the time they injured themselves?

6. What injury was caused to the member of the organisation?

7. Was the activity in which the member of the organisation was participating , at the time they injured themselves an officially authorised and sanctioned activity of the insured organisation? No Yes

8. Was the injured member paid or entitled to receive any income for the activities they were engaged in for the insured organisation at the time of the injury? No Yes

9. If the injured member was a volunteer for the insured organisation , were they travelling directly to or from the voluntary activities or actually engaged in the voluntary activities at the time the injury occurred? No Yes

10. What was the officially authorised and sanctioned activity in which the member was participating when they injured themselves?

11. At what venue did the member injure themselves?

Suburb/town State Postcode

12. What is the injured person's membership/student number of the insured organisation?

13. If the injured person is a university student, are they a student from overseas? No Yes

14. Was the member a fully financial member of the insured organisation at the date they injured themselves? No Yes

15. Please provide the dates of membership of membership of the injured person with the insured organisation:

Membership dates of the injured person are from / / to / /

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

of the (name of organisation)

I declare that the information provided in this certification is ture, correct ad complete to the best of my knowledge and ability.

Signed Dated: / /

Note: The official of the organisation who completes this page of the claim form MUST ATTACH documentary proof that the injured person was a financial member of the insured organisation at the date the member was injured.

PRIVACY NOTICE

At AFA Pty Ltd (AFA) (ABN 83 067 084 333) we are committed to protecting your privacy in accordance with the Privacy Act 1998 (Cth) and the Australian Privacy Principles (APPs).

This privacy notice details how we collect, disclose and handle your personal information as defined in the Act.

Personal information is essentially information or an opinion about an identified individual or an individual who is reasonably identifiable, whether the information or opinion is true or not and whether recorded in a material form or not.

Why we collect your personal information

We collect your personal information (including sensitive information) so we can:

- identify you and conduct necessary checks;
- Determine what service or products we can provide to you e.g offer our insurance products;
- issue, manage and administer services and products provided to you or others, including claims investigation, handling and settlement;
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.

What happens if you don't give us your personal information?

If you choose not to provide us with the information we have requested, we may not be able to provide you with our services or products or properly manage and administer services and products provided to you or others.

How we collect your personal information

Collection can take place through websites (from data you input directly or through cookies and other web analytic tools), email, by telephone or in writing.
We collect it directly from you unless you have consented to collection from someone other than you, it is unreasonable or impracticable for us to do so or the law permits us to.

If you provide us with personal information about another person you must only do so with their consent and agree to make them aware of this privacy notice.

Who we disclose your personal information to

We share your personal information with third parties for the collection purposes noted above.

The third parties include: our related companies and our representatives who provide services for us, our agents or contractors, our insurers, other insurers and reinsurers, your agents, premium funders, other insurance intermediaries, underwriting agents, Lloyd's Regulatory Division, our legal, accounting and other professional advisers, data warehouses and consultants, providers of medical and non-medical assistance and services, translators, investigators, loss assessors and adjusters, credit agencies, credit card providers and other parties we may be able to claim or recover against, your employer (if a corporate policy), anyone either of us appoint to review and handle complaints or disputes, other companies in the event of a corporate sale, merger, re-organisation, dissolution or similar event and our alliance and other business partners and any other parties where permitted or required by law.

We may need to disclose information to persons located overseas. Who they are may change from time to time. You can contact us for details or refer to our Privacy Policy available at our website afainsurance.com.

In some cases we may not be able to take reasonable steps to ensure they do not breach the Privacy Act and they may not be subject to the same level of protection or obligations that are offered by the Act. By proceeding to acquire our services and products you agree that you cannot seek redress under the Act or against us (to the extent permitted by law) and may not be able to seek redress overseas.

More information, access, correction or complaints

For more information about our Privacy practices including how we collect, use or disclose information, how to access or seek correction to your information
or how to complain in relation to a breach of the Australian Privacy Principles and how such a complaint will be handled, please refer to our Privacy Policy.
It is available at our website afainsurance.com or by contacting us or our Privacy Officer at AFA, PO Box R1852 Royal Exchange NSW 1225 or by email to privacy@afainsurance.com, or by telephone on 1300 728 997.

Your Choices

You consent to this use and these disclosures unless you tell us otherwise. If you wish to withdraw your consent, including for things such as receiving information
on products and offers by us or persons we have an association with, please contact us.

Contact us

By phone: 1300 728 997

By email: privacy@afainsurance.com

In writing: PO Box R1852, Royal Exchange NSW 1225

AFA INSURANCE

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Once the claim form has been completed, signed and dated please send it, along WITH ATTACHMENTS, to:-

AFA CLAIMS DEPARTMENT, PO Box R1852, Royal Exchange NSW 1225

OR TO YOUR INSURANCE BROKER

OR email it to: enquiries@afainsurance.com

If you have any questions, or if you need assistance with understanding or completing this form, you can contact us on (toll-free) 1300 728 997. Please ensure that you keep copies of all documentation sent to AFA.