Pony Club Insurance Scheme

Personal Accident Claim Form – Voluntary Helpers

Please read this page before completing the Claim Form.

Dear Voluntary Helper,

Thank you for your Claim Form request. This letter contains important information relevant to your Claim.Please read it carefully and make sure you understand its contents.

We require the Claim Form to be fully completed and returned within 120 days of your injury.

DO NOT wait until treatment is complete before submitting the Claim Form.

1. The Medical Report of page 7 must be completed by the main Doctor, Chiropractor, Physiotherapist or Dentist who is providing treatment for your injury.
2. For Claims under the "LUMP SUM" Net Loss of Income Benefit your Employer must complete the Employer's Statement on page 6 and forward it directly to Gow-Gates. A Return to Work Statement from your Employeris also required before processing can be completed. If you are self employed, the financial statement on page 6 showing income details must be completed by your Accountant.
3. Please send all receipts for Non-Medicare Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts.
4. Insurers will commence working on your claims immediately however, Claims cannot be settled (entitlementscalculated) until all treatment to the injury has been completed, all accounts have been paid and refundsfrom your Private Health Insurer have been obtained. Claims for Loss of Wages will only be processed once insurers have been provided with a Return to Work date.
5. In most cases, there are varying Excesses on claims for Medical Expenses and an excess of varying periods on claims for loss of earnings. For precise details and information regarding Policy maximums and excesses,please contact your Club or Association.
6. Gow-Gates values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement please visit our website at www.gowgates.com.au

If you have any queries, please call us immediately:

T: 02 8267 9999

E: equestrian@gowgates.com.au

Please send all correspondence to

CLAIMS DEPARTMENT

Gow-Gates Insurance
Brokers Pty Ltd. GPO
Box 4731, Sydney, NSW
2001

Before you commence filling in this form, please make sure you have read and fully understood the dialogue on the front of the claim form as it contains important information relating to your claim. If you have any questions at all about its content or meaning, please contact the Gow-Gates office.

PART 1 – Contact/Claimant Details

Name of Claimant			
Date of Birth		Sex	
Occupation			
Home Address			
Correspondence Address			
Telephone		Mobile	
Email		Alternative Phone	
Australian Permanent Residence?		Other (please specify)	
Sport			
Club:			

1. a) Please give a full description of the circumstance of the accident which led to the injury

1. b) When did the injury occur?		Date		Time	
1. c) Please provide the address of where the injury occurred					
2. a) What injuries did you receive?					
2. b) When did you first consult a practitioner?				Date	
2. c) Is treatment complete for this injury?	☐ Yes	No ☐		If NO, please notify us in writing as soon as it is.	
3. Were you admitted to Hospital?	☐ Yes	No ☐		If yes, Name and Address of hospital	

3. a) Were you an	In patient:	☐ Yes	☐ No	Outpatient:	☐ Yes ☐ No
3. b) What was the Name of the Attending Doctor?					
4. Are you now or have ever been subject to or affected by other injury or diseases, deformity, defect of sense, infirmity or weaknesses?		☐ Yes	No ☐		
If yes to the above, please provide details					
5. Have you ever lodged a personal accident claim before?		☐ Yes	No ☐		
If yes to the above, please provide details					
6. a) Are you a member of a Private Health Insurance Fund?		☐ Yes	No ☐		
If yes to the above, please provide details					
6. b) If yes, are you entitled to claim for any of the following benefits?	Private Hospital ☐	Physiotherapy ☐		Dental ☐	
	Chiropractic ☐	Ambulance ☐		Massage ☐	
	Other ancillary services Please give details				
7. If you intent making a loss of wages claim, are you making or entitled to make a claim in respect of this injury for any of the following?	Sick leave ☐			Workers Compensation ☐	
	Motor Government Benefits ☐			Superannuation Life Insurance ☐	
	Income Protection (for example: Personal or via Superannuation Fund) ☐			Centrelink Sickness ☐	

PLEASE NOTE

Original receipts and all statements of any benefits received from any source must be sent to Gow-Gates as soon as possible. Failure to do so will result in Settlement Delays. Please also remember to inform us in writing when your treatment is complete. This will also reduce delays in settlement of your claim.

PART 2 – Settlement Details

NOTE – For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

☐ Mail Cheque ☐ Direct Bank Deposit (if bank deposit, please give details below)

BANK NAME										
BENEFICIARY NAME										
BSB NUMBER							Maximum 6 digits			
ACCOUNT NUMBER										Maximum 9 digits

PART 3 – Declaration and Authorisation by Injured Person

NAME:

Surname Given Names

I hereby authorise any hospital, physical, medical practitioner, medical specialist or any other person who has attended me and/or employer of mine, past or present, to furnish Gow-Gates and/or its representatives with any and all information with respect to any sickness or injury, medical history, consultants, prescriptions ortreatment, copies of all hospital or medical records and copies of all records of employers including verification or my earnings.

I acknowledge that any personal information that I have or will provide to Gow-Gates is necessary for and willbe used in processing, assessing, investigation or review of this claim. I hereby authorise Gow-Gates and/or itsrepresentatives and consent to Gow-Gates and/or its representatives and its authorised agent to disclose anypersonal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed/authorised broker, account broker, and/or broker of the entire/body corporate/organisation insured (Insured), State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personalinformation (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, I can contact the Gow-Gates office.

I agree that a photocopy / scanned copy of this authorisation shall be considered as effective and valid as theoriginal.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

Signature Date / /

WARNING: Persons found to have lodged a fraudulent claim are liable for prosecution.

Complete this section only if you wish to claim for loss of earnings

PART 4 – Details of Employment

PLEASE NOTE

A claim cannot be made unless the claimant was gainfully employed at the date of injury

The Claimant must be continuously and totally disabled for more than the excess period noted in the Policy

Current Employer's Name		
Current Employer's Address		
Contact Name		
Contact Telephone Number		
1. At the time of the accident were you (please select as appropriate)	Full time Employee ☐	
	Part time Employee ☐	Working hours per week?
	Self Employed on a full-time basis ☐	
	Period of employment	
2. What is your occupation/position?		
3. What are your Gross Earnings per annum from this employer?		
4. When did you cease work as a result of your injury?		
5. Have you returned to work?	☐ Yes No ☐	
	If yes, when?	

6. Please give details of your entitlements (if any) to each of the following benefits:

	Number of Weeks	Weekly Amount	Total Entitlement
a. Sick pay from your employer			
b. Other insurance benefits including Personal Accident Policies			
c. Centrelink			

d.	Other salary, wages, income or pay of any nature whatsoever being:		
	If other sources, please describe briefly		
		Total Entitlements =	
7.	What was your income from all sourced in the twelve months period prior to your accident?	Total Annual Income	
		From All Sources	
8.	Have you worked at more than one place of employment within the twelve-month period prior to your accident?	☐ Yes	No ☐
If yes, please provide details showing full names and addresses – no abbreviations			
a) Former Employer			
Telephone Number			
Address			
Occupation/Position			
Period of employment			
Please list any additional former employers on a separate list. Leave black if not applicable			

Employers Statement – to be completed by Claimant's Current Employer

I_____Manager / Accountant / Director / Partner (please select) of _____(Name of Company) at_ _____(Address of Company)

confirm that_____has been employed continuously by this firm in the position of_____

since_____/_____/_____

His/Her gross earning since the above date of employment (if less than 12 months ago) or for the past 12 months up to the date of his/her injury as described on this claim form amounted to $_____

At the_____/_____/_____(date of injury), the claimant was entitled to_____sick days pay.

I confirm that the claimant was not entitled to receive, nor did receive any form of remuneration whatsoever from this firm, his employer, in respect of his/her period of disablement commencing at the above-mentioned date of injury; except as follows:

_____

_____

Signature_____Date_____/_____/_____

Accountant's Statement – to be completed by Claimant's Accountant – For Self Employed Person's Only

I_____Manager / Accountant / Director / Partner (please select) of _____(Name of Company) at_ _____(Address of Company) confirm that our firm acts as Accountants for_____(Name of Claimant) at (Address of Claimant)

and that His/Her gross earnings (before tax but after expenses) for the 12 months period ending /_____/_____(date of injury) amounted to $_____

Income Protection Yes / No If Yes, name of company_____

Signature_____Date_____/_____/_____

Medical Report

PLEASE NOTE – These questions are to be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor.

IMPORTANT: If you are claiming for Loss of Income this section MUST be completed by your DOCTOR. The insured is responsible for the completion of this form and any charges incurred for its completion.

Patient's Details

Name	
Address	
Telephone	
Email	
What is disabling the patient? (Please give a complete diagnosis of this condition)	

History

1.	When did the patient first receive medical treatment for this injury?	
2.	a) Was there a previous history of this or similar condition?	☐ Yes ☐ No
	b) If yes, please state the condition and advice when previous treatment was given	
3.	a) How long have you known the patient?	
	b) Are you the claimant's regular practitioner?	☐ Yes ☐ No
	c) If no, please advise who is	

Injury

1. When did the patient suffer the injury?	
2. What were the circumstances surrounding the injury?	

Degree of Disability

1. Patients Occupation		
2. When was the patient obliged to cease work?		
3. If the patient is disabled, when approximately will the patient resume:	a) Some duties	
	b) Full duties	
4. If patient has recovered, when was the patient able to resume	a) Some duties	
	b) Full duties	

Treatment of Present Condition

1. When were you consulted?	a) Initially	
	b) Most recently?	
2. How often has the patient consulted you?		
3. Was the patient confined to hospital?	☐ Yes	No ☐
4. If yes, please advise	a) Name off hospital	
	b) Period of Confinement from	

5. Was confinement in a convalescent home necessary after hospitalisation?		☐ Yes ☐ No
6. What are the current subjective symptoms?		
7. Please give results of any objective findings	a) X-Ray's, MRI's	
	b) Other tests – please advise tests done and findings	
8. What surgical procedures have been performed?		
9. What surgical procedures have been contemplated?		
10. Are there any underlying conditions affecting recovery from the current condition?		☐ Yes ☐ No
If yes, could you advise the nature of underlying conditions and how they affect disability and recovery:		
11. Has patient any other physical or mental impairment?		☐ Yes ☐ No
If yes, please describe		
12. Please advise names and addresses of other treating physicians	Name	
	Address	
13. If you have terminated treatment, please advise date		
14. What is the current prognosis?		
15. Are there any further remarks which may assist in assessing this conditions?		
16. Is there any permanent disability at present?		☐ Yes ☐ No
If yes, please explain giving an estimated percentage of loss of function		

Physicians' details

Full Name	
Qualifications	
Street Address	
Telephone	
Email	
Website	
Signature	
Date	