HARNESS RACING VICTORIA- GROUP PERSONAL ACCIDENT INSURANCE

HOW TO CLAIM OVERVIEW

This guide describes what you can expect when making a claim, and what we will expect from you.

To make a claim, please take the following steps:

STEP 1

Refer to the Policy Schedule and Product Disclosure Statement (PDS) available from your sporting association (HRV) for full details of benefits, limits & conditions that apply to the policy of insurance. Alternatively, please call the Gow-Gates Claims Team on (02) 8267 9999 or by emailing Gow-Gates at sportsclaims@gowgates.com.au

STEP 2

Read and complete all relevant pages of this claim form by providing as much information as possible.

STEP 3

Lodge the completed claim form by email to sportsclaims@gowgates.com.au

It is important that you fully complete all requested claim forms and submit them to either Gow-Gates or HRV without delay after your injury occurs – failure to complete and submit all requested forms promptly and efficiently may affect SLE's ability to assess your claim. **Do not wait until your treatments have concluded before you lodge your claim.**

STEP 4

Gow-Gates will submit your claim to SLE, once your claim is submitted, SLE will respond to you by acknowledging receipt of your claim, confirming your Claim Number and assigning a claims officer to review your claim. You will be contacted shortly thereafter by your claims officer within **10 business days** to confirm our initial assessment of your claim.

If further information is needed to enable SLE to make a decision about any aspect of your claim, SLE will contact you within **10 business days** to tell you what additional information they will need to make the decision. SLE will tell you about the progress of your claim at least every **20 business days**, and will respond to your routine inquiries about your claim's progress within **10 business days**.

SLE Worldwide Australia Pty Limited.
PO BOX H308, AUSTRALIA SQUARE NSW 1215
E: CLAIMSENQUIRIES@SLEWORLDWIDE.COM.AU
PH: 1800 002 676

Harness Racing Victoria Personal Accident Claim Form

Policy: Harness Racing Victoria		**Policy Number**: 241885501349	

SECTION 1 - TO BE COMPLETED BY THE CLAIMANT

Claimant's Name:			
Occupation:			
Injury Location:			
Home Address:			
Telephone (private)		**Telephone (work)**	
Telephone (mobile)		**Email (important)**	
Date of Birth			
Height		**Weight**	

For what are you claiming? ☐ Weekly Benefits (Loss of Income) ☐ Medical and/or Other Expense Reimbursement ☐ Capital Benefit (e.g. Loss of limb) ☐ Ambulance Reimbursement

INJURY DETAILS:

What is the nature of your injury?

Please describe the injured body part/s and indicate: ☐ Left ☐ Right ☐ N/A

How did the injury occur? ☐ Driving in a race ☐ Driving at training ☐ Other	Please provide full details (*attach additional pages if more space is required)*:		
When did the injury first occur?	Date	Time	am/pm
Did the injury cause you to stop work?	☐ Yes ☐ No	If Yes state when	/ /
Have you returned to work full-time?	☐ Yes ☐ No	If Yes state when	/ /
Have you returned to work part-time?	☐ Yes ☐ No	If Yes state when	/ /
– if returned to work, what hours are you working?	____Days ___Hours per week		
– if returned to work, what duties can you perform?			
Is this condition due to injury or sickness arising out of your employment?			☐ Yes ☐ No
- If yes give details			

SECTION 1 (CONTINUED) - TO BE COMPLETED BY THE CLAIMANT

Who is your usual family doctor?				
Name			Telephone Number	
Address				
How long have you been going to this doctor?				
What is the name of the doctor you first consulted for this injury?				
Name			Telephone Number	
Address				
When did this consultation take place?				/ /
Have you consulted any other medical practitioner for this injury?				☐ Yes ☐ No
Name			Telephone Number	
Address				
When did you first see this doctor?				/ /
Did you go to hospital?				☐ Yes ☐ No
Hospital Name			Telephone Number	
Address				
Admission Date	/ /	Discharge Date	/ /	No of Days
During the 24 hours before the injury, did you drink any alcohol or take any drugs?				☐ Yes ☐ No
State types & quantities				
Is this a recurrence of a previous injury or condition you have had in the past?				☐ Yes ☐ No
Diagnosis / Treatment Received				
Treatment Start	/ /	Treatment Completed	/ /	No of Days
Doctor's Name			Telephone Number	
Address				
Have you had any other significant medical or surgical treatment in the past 5 years?				☐ Yes ☐ No
Diagnosis / Treatment Received				
Treatment Start	/ /	Treatment Completed	/ /	No of Days
Doctor's Name			Telephone Number	
Address				
Are you affected by any other long term or chronic disability?				☐ Yes ☐ No
Provide Diagnosis / Treatment Details				

SECTION 1 (CONTINUED) - TO BE COMPLETED BY THE CLAIMANT

OTHER INSURANCE / BENEFITS CLAIM

Are you continuing to receive any regular income from self-employment? ☐ Yes ☐ No

If 'Yes' please provide details *(if you require more space please attach additional pages)*:

Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, CTP, sports body or any income replacement. ☐ Yes ☐ No

Name of Insurer, Claim Number & Telephone number

Type of cover

Amount claimed per week / amount received

PRIVATE HEALTH COVER

Do you have private health insurance? ☐ Yes ☐ No

If 'Yes', what type of membership do you have?

☐ Hospital cover only ☐ Extras cover only ☐ Hospital plus extras cover ☐ Ambulance only cover ☐ Overseas visitors cover

Name of Health Insurer:	Membership number:

PAYMENT OF BENEFITS - ELECTRONIC BANKING DETAILS

Please provide Electronic Bank Account Details to ensure prompt payment should your claim for benefits be successful:

Account Holder's Name: …… Account No: ……..…...

BSB No: …… Name of Bank / Credit Union etc: ……

I hereby declare and warrant that the above particulars are my banking details which are true and correct in every detail. Further, I authorise and request that SLE Worldwide Australia Pty Ltd credit the above nominated bank account with any monies payable to me in respect of this claim. I shall notify SLE Worldwide of any changes to the above details immediately in writing.

Name (please print): _____

Signed: _____ Date: _____

Please note that SLE Worldwide accept no responsibility for the incorrect allocation of payments by your nominated bank.

SECTION 1 (CONTINUED) - TO BE COMPLETED BY THE CLAIMANT

MEDICAL AUTHORITY & DECLARATION

**** I**.....*[insert Claimant Name in block capitals]* **DECLARE THAT**:

• I will use my best endeavors and render all reasonable assistance and co-operation to SLE Worldwide in the assessment of my claim;
• the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
• I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
• I understand that by investigating my claim or by accepting proofs of my claim, SLE has made no acceptance of liability, nor waived any of its rights in defense of any claim arising under the policy.
I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as SLE shall reasonably require for its assessment of initial or ongoing benefits for my claim including, without limitation:
• all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
• my Health Insurance claims history, including Medicare;
• any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
• any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

SIGNATURE OF CLAIMANT:		**DATED**	
SIGNATURE OF WITNESS:		**DATED**	

NOMINEE AUTHORITY (OPTIONAL)

What is an Authorised Nominee?

• You may wish to have someone else act on your behalf when dealing with SLE Worldwide Australia Pty Limited (SLE).
• Where you nominate someone else to deal with us on your behalf, they are noted on your claim record as an 'Authorised Nominee'.
• You can remove this nomination at any time by writing to SLE

What is an Authorised Nominee able to do?

• By nominating an Authorised Nominee below, you give them the ability to do the following on your behalf in relation to your claim:
- Enquire about and discuss your claim;
- Receive correspondence from SLE about your claim, including where relevant, your personal circumstances;
- provide information (including personal information) to SLE about your circumstances relevant to the claim;
- make a complaint about SLE's products, services, staff or handling of your claim.

Nominee Full Name..... *[insert name block capitals]*

Nominee's relationship to Claimant: ……
[parent / guardian / spouse / power of attorney / other]

Please select one and complete <u>one only</u>:

□ I am 18 years of age or older:

CLAIMANT'S SIGNATURE: …… **DATED** ……/……/……

□ If the Claimant is under 18 years of age:

PARENT / GUARDIAN NAME:.....*[insert name block capitals]*

PARENT / GUARDIAN SIGNATURE: …… **DATED** ……/……/……

Disclosure Statement and Privacy Consent

SLE Worldwide Australia Pty Limited (**SLE**) is committed to protecting the privacy of the personal information you provide to us.

In accordance with the Privacy Act 1988 (and subsequent amendments) We will collect and use the personal information about you requested on this form and via our online portal to enable us to consider your claim. We may also need to collect additional information (including personal information about you) in connection with your claim from the Health Insurance Commission, any hospital, physician or other person or organisation who has or will be providing medical services, treatment or otherwise attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if we investigate your claim.

If you do not provide us with this information, we may not be able to process your claim.

We may disclose the personal information we collect on this form and/or via our online portal and any other additional information we collect in relation to this claim to:

- our relevant staff and contractors involved in delivering our services;
- if a broker collects the information from you, to that broker (this is applicable to information requested from you on the claim form);
- to your employer;
- to your sports association (and any insurance intermediary appointed by your sports association) to confirm your eligibility to claim under a policy arranged by or on behalf of it and to improve your sports association's risk management functions;
- to the insurer, underwritten for certain underwriters at Lloyds of London by their agent SLE Worldwide Australia Pty Limited;
- to reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- to facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- to consultant doctors, physicians and other providers of medical treatment (in connection with the handling of your claim);
- to claims investigators and surveillance officers (in circumstances where the claim is investigated by us);
- if required to do so by a law enforcement body or by law; and

You may request access to your personal information we hold about you and where necessary correct any errors in this information subject to the provisions of the Privacy Act 1988 (some restrictions and costs may apply). Entities to whom information is disclosed as set out above will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.

By completing and returning this form to us, you agree to us collecting the additional information referred to above from the parties specified above in connection with your claim and agree to us using and disclosing your information as set out above. This consent to the use and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice. 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

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold about you is accurate, complete and up-to-date.

I agree that a photocopy of this document shall be considered as effective and valid as the original and specifically authorise its use as such.

Name of Claimant …….

Signature of Claimant …… Date ……./……../…….

Parent / Guardian (under 18's)……... Date ……./……../…….

MEDICAL PRACTITIONER'S STATEMENT

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL DOCTOR

The Claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly							
Patient's Name		DOB		Height		Weight	
Complete Diagnosis (if fracture or dislocation, describe nature and location i.e.: Simple, Compound							
Present symptoms:-							
If available please provide a copy of any imaging reports		Is this condition: ☐ an injury or ☐ an illness					
Does the patient have any other injury or illness that is contributing to the condition? e.g. Osteoporosis						☐ Yes ☐ No	
Provide Details							
Is condition due to injury or sickness arising out of the patient's employment?						☐ Yes ☐ No	
Provide Details							
What were the circumstances surrounding the onset of injury as elicited by you?							
Date of onset/first symptoms?						/ /	
When did the patient first consult you for this condition?						/ /	
Has the patient ever had the same or similar condition?						☐ Yes ☐ No	
From when & Diagnosis							
Name of patient's usual doctor/medical practice							
How long have you been the patient's usual doctor/medical practice?							
Has the patient been hospitalised	Date of Admission	/ /	Date of Discharge	/ /			
Name of Hospital							
Has the patient had surgery or is it anticipated?						☐ Yes ☐ No	
Provide Details							
Date performed or anticipated	/ /	Give name of hospital?					
Did you provide other medical services (including pathology) to the patient?						☐ Yes ☐ No	
Provide Details	/ /						
	/ /						
Was the patient referred by you or to you?						☐ Yes ☐ No	
Provide Details	/ /	Doctors details					
Has the patient been prevented from working due to this injury?						☐ Yes ☐ No	
If yes	Totally disabled (unable to perform any part of their usual occupation)	/ /	to	/ /			
	Partially disabled (able to perform part of their occupation)	/ /	to	/ /			
If partially disabled, what percentage of their usual duties can the patient currently perform?						%	
Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body?						☐ Yes ☐ No	
Name of Company / Contact / Claim number							
SIGNATURE OF MEDICAL PRACTITIONER:		**Date**					
NAME + QUALIFICATIONS (PRINT):		**Telephone**					
ADDRESS							

EMPLOYMENT DECLARATION FOR LOSS OF INCOME CLAIMS

SECTION 3 - TO BE COMPLETED BY YOUR EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)

Claimant's Name:			
Employer/Company Name:			
Contact Person:			
Postal Address:			
Phone: (Bus. Hours)		Mobile:	
Business Email:			
Employment Status: ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed			
Employment Details			
Employee's NET weekly salary	$ / week		
Employee's GROSS weekly salary	$ / week		
IF SELF-EMPLOYED OR CASUAL, PLEASE PROVIDE AVERAGE WEEKLY SALARY BASED ON 12 MONTH PERIOD DIRECTLY PRIOR TO INJURY.			
Injury Details			
Date employee ceased work due to Injury:	/ /		
Date employee expected to resume duties:	/ /		
Return to Work			
Has the employee returned to work?	☐ Yes ☐ No		
If YES, what date did the Employee return?	/ /		

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: …… **DATED** ……/……/……

** Accountant's signature (if claimant is self-employed)*

NAME (PLEASE PRINT): ……

POINTS TO REMEMBER ABOUT YOUR GROUP PERSONAL ACCIDENT INSURANCE CLAIM:

- You must follow medical advice from a registered medical practitioner as soon as possible after sustaining an injury;
- In the event of an injury you should notify your club or community association as soon as possible, describing the occurrence;
- At our expense, you must undergo any independent medical examination we reasonably require in relation to your claim;
- At your expense you must provide us with information about the claim we reasonably ask for. This includes:
    - Your completed claim forms;
    - Letters and notices you receive from anyone else about your injury and/or treatment;
    - Documents to substantiate your pre-injury earnings (where relevant to the claim);
    - Proof of any expenses you wish to claim (including all relevant Medical doctors' referrals for treatment, itemised receipts for payment of expenses, and medical certificates that relate to your claim)
- It is important that you monitor the progress of your claim by reading all notices we give you about your claim. These will be sent to your last known address (including if it is an electronic or e-mail address). If you change your address, please make sure you tell us as soon as possible.
- If you have a complaint about anything to do with how we handle your claim, then you may make a complaint to us through our complaints process – please see our website under 'Help and Support' for more information on our Compliments, Complaints and Dispute Resolution Policy.

WHAT CAN AFFECT YOUR CLAIM

If the policy provides for payment of benefits during periods of Temporary Total Disablement (such as where you are wholly and continuously unable to work or attend school or studies) we will reduce the amount of a claim by any deferral period shown in the policy terms and conditions or in the Policy Schedule. Deferral periods are periods which defer the commencement of any applicable benefit period.

We will also apply any limits and sub-limits to, and deduct any excesses from, your claim where they are shown in the Policy Schedule or the terms and conditions of the insurance policy.

We may be entitled to refuse to pay or to reduce the amount of a claim if:

- It is in any way fraudulent, or
- Any fraudulent means or devices are used by you or anyone acting on your behalf to obtain any benefits under the policy of insurance.

NOTICE REGARDING MEDICARE

SLE does not provide cover for any expense that Medicare covers either in part or in full. This is because Government legislation (including the *Health Insurance Act 1973*) prohibits SLE from covering expenses claimable from Medicare, including the balance of monies due or payable by you after deduction of any Medicare benefit or rebate from the actual expense incurred (commonly known as the "Medicare Gap").

GUIDE TO CLAIMING BENEFITS FOR NON-MEDICARE MEDICAL EXPENSES

Benefits for Non-Medicare Medical Expenses are limited for 12 calendar months from date of injury. When claiming benefits for Non-Medicare Medical Expenses please remember to:

- Obtain a referral from your treating Medical Doctor or Dentist to certify that any non-Medicare medical treatment expense you wish to claim is necessary to treat your injury. A Doctor's referral should be obtained before undergoing any treatment that you wish to claim;
- Have your treating Medical Doctor or Dentist complete the Medical Practitioner Statement (without expense to SLE Worldwide) prior to lodging your claim; and
- Submit copies of all paid invoices, receipts and referrals for the treatment you are claiming.
- Additionally, if you have private health insurance it is a condition of the Policy that you must also submit your expenses to your health insurer **first** and claim any available rebate prior to submitting the expenses to us. Please send a copy of your private health insurer's rebate advice to us.

GUIDE TO CLAIMING BENEFITS FOR TEMPORARY TOTAL DISABLEMENT (LOSS OF INCOME)

When claiming benefits for Temporary Total Disablement (loss of income) please remember to:

- Fully complete the applicable claim forms;
- Have your treating Medical Practitioner or Dentist complete the Medical Practitioner Statement (without expense to the Insurer) prior to submitting a claim;
- At least every four weeks, submit a medical certificate issued by a medical doctor for all periods of Temporary Total Disablement (i.e. periods that you are unable to attend work or school or for which personal care is medically necessary). We do not accept back dated certificates.
- If you are a wage or salary earner, have your employer complete the Employment Declaration and submit a Tax File Number Declaration Form. If you are self-employed, you must submit proof of earnings such as your most recent tax return or a letter from your accountant or tax agent if requested.
- Submit receipts for eligible home tutorial expenses or personal care/nurse care expenses (if applicable) which you incur whilst certified as being under Temporary Total Disablement.

If your Temporary Total Disablement is continuing, you must submit medical certificates from a Doctor every four weeks to verify your incapacity and evidence that you remain under the regular care of a Medical Practitioner. Temporary Total Disablement benefits will not be paid until all requested proof of loss documents are submitted.

PRIVACY NOTICE

SLE Worldwide has always protected the privacy of personal information of our valued clients. The standards by which we handle this personal information have now been set by the Privacy Act 1988 and the National Privacy Principles (NPP).

SLE Worldwide and its staff, agents and contractors have agreed to hold all information in confidence and not use it for any purpose except to carry out the service they are providing. We do not sell or share names, addresses or any other information with third parties, except to the extent necessary to complete our obligations as an Underwriting Agency or as stated in our Privacy Policy, a copy of which is published on our website at www.sleworldwide.com.au

How & why do we require your Personal Information

We collect information either directly from the relevant individuals or in some cases, from third parties. They may provide information for someone else where relevant to the assessment of your claim. All such information is collected for the purpose of allowing us to properly administer your claim.

What we expect of you

When you provide us with information about other individuals, we rely on you to have made, or make them, aware that you will or may provide their information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties will use it for and how they can access it. If it is sensitive information, we rely on you to have obtained consent to the above. If you have not done these things, we expect you to tell us before you provide the relevant information.

Transfer of information overseas

We may transfer your personal information overseas where it is necessary for the delivery and/or facilitation of the delivery of insurance, underwriting, risk management or claims handling and settlement services. Some insurers or reinsurer's are based overseas and we may need to provide your personal information to them to administer your claim.