SLE Worldwide Australia Pty Limited
ABN: 15 066 575
General: 02 9249 4850
Claims: 1800 002 676
Fax: 02 9249 4840
Claims Email: claimsenquiries@sleworldwide.com.au

What to expect when making a claim

When making a claim under your sporting association's Group Personal Accident Insurance Policy, please remember the following important points:

- You must follow medical advice from a registered medical Doctor as soon as possible after sustaining an Injury.
- You must provide us with information about your claim (at your expense) where we reasonably ask for it. This includes any requested claim forms.
- Claim forms we will usually require include:
    - Club's Declaration – *to verify the circumstances in which your Injury occurred.*
    - Medical Practitioner's Statement – *to confirm the extent of Injury sustained and verify the medical cause of your Injury.*
    - Disclosure and Privacy Consent – *to enable us to request information about your injury where necessary and relevant to your claim.*
    - Electronic Bank Details – *to enable us to pay benefits to you under the Policy.*
    - Employment Declaration - *to substantiate your pre-injury income (where Loss of Income benefits are claimed)*.

Failure to fully complete and return all requested forms and reasonably requested information promptly and efficiently may affect and delay our ability to assess your claim.

For full details of eligible expenses and benefit limits, please refer to the Policy Schedule and Product Disclosure Statement (PDS) available from your sporting body or their Broker. Alternatively, please contact us for a copy by calling us on 1800 002 676.

What can affect your claim

We will reduce the amount of a claim by any deferral period shown in the policy terms and conditions or in the Policy Schedule. We will also apply any percentage reductions, limits, sub-limits, and excesses to your claim where any such percentage, limit, sub-limit and/or excess is shown in the Policy Schedule.

Important note regarding claims for medical expenses

SLE does not provide cover for any account that Medicare covers either in part or full. *The Health Insurance Act 1973* (Cth) prohibits SLE from covering expenses claimable from Medicare, or any Medicare Gap.

We do provide cover for **Non-Medicare** Medical Expenses. We will pay the percentage amount shown in the Policy Schedule for expenses relating to private hospital, dental (sound and natural teeth), ambulance, chiropractic, physiotherapy, or any similar registered provider of medical/allied health services, provided a legally qualified Medical Practitioner has certified that the treatment was necessary.

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How to claim Non-Medicare medical expenses

Please note Non-Medicare Medical Expenses are ***limited for 12 calendar months from date of Injury***. When claiming Non-Medicare Medical Expenses you must:

1. Obtain a referral from your treating Medical Practitioner or Dentist to certify that any medical treatment is necessary. Referrals must be obtained before undergoing treatment.
2. Have your treating Medical Practitioner or Dentist complete the Medical Practitioner Statement (without expense to the Insurer) prior to submitting a claim; and
3. Submit copies of all receipts, accounts and referrals for the treatment you are claiming.
4. If you have private health insurance, you must submit your receipts and accounts to your health insurer prior to submitting your claim to us.

How to claim loss of income

The policy has deferral periods which defer the commencement of your benefit period by up to 28 days (depending on your Policy Schedule). This means that you will not be paid benefits for loss of income you suffer during the deferral period. For example, a deferral period of 28 days means you will not be paid for the first 4 weeks off work.

When claiming for Loss of Income you must:

1. Fully complete the required forms (club declaration and online Injury Details questionnaire);
2. Have your treating Medical Practitioner or Dentist complete the Medical Practitioner Statement (without expense to the Insurer) prior to submitting a claim;
3. If you are a wage or salary earner, have your employer complete the Employment Declaration, or
4. If you are self-employed, attach proof of earnings such as your most recent tax return or BAS Statement.
5. At least every four weeks forward medical certificates for all periods off work. We do not accept back dated certificates.

If your disability is continuing, please forward medical certificates every four weeks to verify your incapacity for work and verify that you remain under the regular care of a medical Doctor. Loss of income benefits will not be paid until all statements and documents are submitted.

Please remember

- Excesses, sub-limits, benefit periods and percentages of cover apply under the Policy Schedule;
- Please check with your sporting association, their Broker or phone us on 1800 002 676 for details of exact cover.

IMPORTANT INFORMATION – PLEASE READ

Claiming Medical Expenses

We will reimburse **Non Medicare** Medical Expenses incurred within twelve months of your injury. Eligible expenses are reimbursed at the rate of 100% of expenses incurred up to a maximum amount of $3000, less the $100 Policy excess applicable to all claims. Please note the $100 does not apply to ambulance expenses.

Non Medicare Medical Expenses:

- means medical treatment expenses that **do not** attract a Medicare rebate;
- covers treatment referred by a doctor to a registered private hospital, registered physiotherapist or a similar registered provider of medical services before you start treatment (backdated referrals will not be accepted);
- includes ambulance expenses;
- includes dental treatment incurred to sound and natural teeth, excluding dentures.

To claim reimbursement of Non Medicare Medical Expenses you will need to:

1. Claim any private health rebate from your Private Health Insurer (if you have one) **before** you submit the expenses to us.

2. Send us a copy of your doctor's referral, your receipts for payment of the expenses, and evidence of any applicable Private Health Insurance rebate.

Claiming Loss of Income

We will pay a maximum of $300 per week for up to 52 weeks for loss of Income suffered as a result of an injury after the 28 day deferral period. Benefits are capped at 100% of your average weekly Income earned during the twelve (12) calendar months immediately prior to the injury.

To claim loss of income (Temporary Total Disablement) benefits you will need to:

1. Arrange for your employer or your accountant (if you are self-employed) to complete the employment details section on the claim form and provide us with proof of your Income upon request.

2. Complete a Tax File Number Declaration form and submit the completed form to secure email address tfndeclaration@sleworldwide.com.au

3. Consult your doctor and obtain medical certificates at least every four (4) weeks. Back dated certificates will not be accepted. Medical certificates must be submitted for all periods that you are totally unfit for work.

4. If you have returned to work, please provide a copy of your clearance certificate.

Claiming Travel & Accommodation Expenses

We will reimburse 80% of reasonable travel and accommodation expenses up to a combined maximum of $2000 as follows:

- Fuel and domestic airfare expenses you incur for travelling directly to a hospital or a place of medical treatment where the travel is more than 100km round trip;

- Overnight accommodation in a hotel or motel capped at $150 per night as a result of the emergency attendance by a family member at your place of treatment.

Please note this document contains a summary only and all claims will be assessed pursuant to the terms and conditions contained in the Policy Wording and Schedule.

PO BOX H308 Australia Square NSW 1215
Tel: 02 9249 4850 02 9249 1500
www.sleworldwide.com.au www.pacificund.com.au

ELECTRONIC BANKING DETAILS

PO Box H308, Australia Square NSW 1215
E: claimsenquiries@sleworldwide.com.au Ph: 1800 002 676

ELECTRONIC BANKING DETAILS TO BE COMPLETED BY THE INSURED PERSON

Please Provide Account Details to ensure prompt payment of your benefits.
Name of Bank / Credit Union / Building Society, etc:

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Branch: _____

Account in the Name of: _____

Type of Account: _____

BSB Number: _____

Account Number: _____

I / We, (**please print**)_____ declare and warrant that the above particulars are my banking details which are **true** and **correct** in every detail

Further, I / We authorise SLE Worldwide Australia Limited to credit this Account with any monies payable to me under the Policy of Insurance.

I shall notify SLE Worldwide Australia Limited of any changes to the above details Immediately in writing.

Whilst an original document is preferred a photocopy or faxed form will be accepted.

Name (please print):_____

Signed: _____ Date: _____

NOMINEE AUTHORITY FORM

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 your claim;
- receive correspondence from SLE about your claim;
- provide relevant information to SLE about your circumstances; and
- make a complaint about SLE's products, services, staff or handling of your claim.

Authorised Nominee's Details:

Nominee Full Name: _____

(please print the name of your Authorised Nominee)

Relationship to you: _____

(parent/guardian/spouse/other)

Claimant's Name *(please print)* _____

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

☐ **I am 18 years of age or older:**

Claimant's Signature _____ **Date** ____/____/____

☐ **If the Claimant is under 18 years of age:**

Parent/Guardian Name *(please print)* _____

Parent/Guardian Signature _____ **Date** ____/____/____

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.

We will use the personal information requested on this form to enable us to consider your claim. We may also need to collect additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if your claim is investigated by us.

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

We may disclose your personal information we collect on this form 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 claim form from you, to that broker (this is applicable to the claim form only);
- to your employer;
- to your sports association to confirm your eligibility to claim under a policy arranged by it;
- 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 and physicians (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 (some restrictions and costs may apply).

By completing and returning to us this form and agreeing to us collecting additional information from the parties specified above in connection with your claim, you 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 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 photostat copy of this document shall be considered as effective and valid as the original and specifically authorise its use as such.

Name .....

Claimant Signature..... Date...../...../.....

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

Club Secretary/Treasurer Declaration and Details

To be retained by Insured for Completion on Recovery or returned completed with claim form if recovery complete

I hereby declare that _____ ***(Claimant's name)***

was injured as stated while playing with _____ ***(Club & Grade name)***

on ***(Date)***

Has the Claimant returned to either training or playing?

☐ No, we will advise as soon as the player returns to training playing.

☐ Yes, on ***(Date)***

Did a Medical Practitioner provide a certificate of clearance to return to play? ☐ Yes ☐ No

Club Secretary Name ***(please print Name)***

Home Address

Suburb State Postcode

Office Hours Phone

Club Secretary Signature

Date

Gallagher

Loss of Income

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

Claimant's Name

Employer/Company Name

Contact Person

Postal address

Suburb State Postcode

Phone: (Bus. Hours) Mobile:

Email

Employment Status ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed

Employment Details

Employee's NET weekly salary $

Employee's GROSS week salary $

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 (dd/mm/yyyy)

Date expected to resume duties (dd/mm/yyyy)

Return to Work

Has the Employee returned to work? If YES, what date did the Employee return? ☐ Yes ☐ No

Salary Received

During the period of incapacity, has the employee received a salary? If YES, what for? ☐ Yes ☐ No

Sick Leave ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Annual Leave ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Other ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

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 Date (dd/mm/yyyy)

Gallagher

Loss of Income

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

Claimant's Name

Employer/Company Name

Contact Person

Postal address

Suburb State Postcode

Phone: (Bus. Hours) Mobile:

Email

Employment Status ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed

Employment Details

Employee's NET weekly salary $

Employee's GROSS week salary $

IF SELF-EMPLOYED OR CASUAL, PLEASE PROVIDE AVERAGE WEEKLY SALARY BASED ON 12 MONTH PERIOD DIRECTLY PRIOR TO INJURY.

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Sick Leave ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Annual Leave ☐ Yes ☐ No

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(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 Date (dd/mm/yyyy)

Gallagher

Medical Practitioner's Statement

The *Medical Practitioner's Statement* must be completed by a qualified medical practitioner only such as a Doctor, Surgeon or Physician, not a health professional such as a physiotherapist, chiropractor etc.

The insured is responsible for completion of this form without expense to SLE

1. Name of Patient _____
2. Address _____
3. Date of Birth ____/____/____
4. Occupation _____
5. Gender ☐ Male ☐ Female
6. Are you the regular treating practitioner of this patient?
   - □ Yes, I have treated this patient since _____ *(year)*
   - □ No, the name and address of the regular treating practitioner that the patient is:

   _____

   _____
7. Please provide a complete diagnosis of the condition: _____

   _____

   _____
8. On what date did a medical practitioner initially treat the patient? ____/____/____
9. On what date did the patient consult you for this condition:
   a. Initially? ____/____/____
   b. Most recently? ____/____/____
10. On how many occasions has the patient consulted you for this condition? _____ *(no. of consults)*
11. Was the patient admitted to hospital?

    ☐ No ☐ Yes:

    From ____/____/____ to ____/____/____

    Name and address of hospital _____

    _____

    _____

    Was surgery performed?

    ☐ No ☐ Yes, _____*(procedure)*
12. Is future surgery contemplated?

    ☐ No ☐ Yes, _____*(procedures)*
13. Has the patient undergone diagnostic tests for this condition?

    ☐ No ☐ Yes, please attach the results of the diagnostic tests.

14. What is the nature of the condition?

☐ New ☐ Aggravation of Existing ☐ Recurrence of Previous

15. Are the patient's description of the symptoms and circumstances of the condition consistent with the results of diagnostic tests or the clinical signs of your diagnosis?

☐ Yes ☐ No, please detail _____

16. Has the patient been unable to work due to this condition?

☐ No ☐ Yes, from _____/_____/_____ ***AND:***

☐ The patient returned to work on _____/_____/_____ ***OR***

☐ The patient is unfit for work and is anticipated to be able to resume (compulsory):

Partial duties on _____/_____/_____

Full duties on _____/_____/_____

17. Does the patient have any co-morbidity that will affect recovery from this condition?

☐ No ☐ Yes, _____

18. Is the condition likely to cause any permanent disability for this patient

☐ No ☐ Yes:

Type of Disability_____

Percentage Loss of Function _____(%)

19. Do you have any further information that may assist us to assess the condition of the patient?

☐ No ☐ Yes, _____

_____

Signature: _____Date: _____/____/__

Name *(please print):* _____

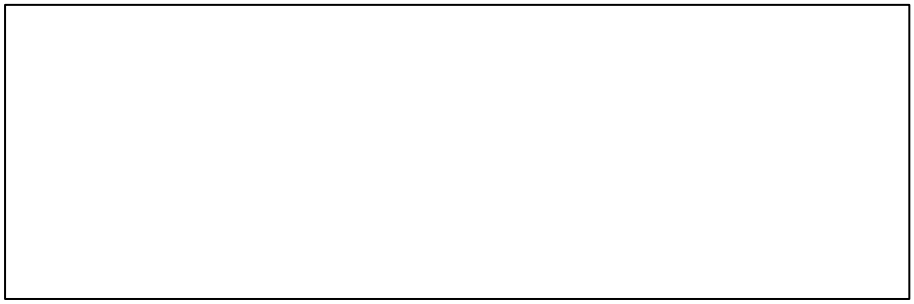
Qualifications: _____

Address _____

_____

Phone No: _____

Medical Practitioner's Stamp



Gallagher