MARSH

PERSONAL INJURY CLAIM FORM

CYCLING AUSTRALIA NATIONAL RISK PROTECTION PROGRAMME

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- You are an Insured person – Cycling Australia member, official, judge, coach or volunteer; and
- You have sustained an injury – whilst participating in a cycling activity/event; and
- You have incurred costs – Non-Medicare medical costs

WHO IS MARSH?

Marsh work with Cycling Australia to arrange and manage the insurance policies protecting cycling and its members.

WHO IS SLE?

SLE is the insurance company offering Personal Accident insurance to Cycling Australia members.

Before completing this form, please read the Product Disclosure Statement (PDS) on our website www.marsh.com/au/financial-services-guide.html

WHAT IS COVERED?

Non-Medicare Medical Costs

Death & other Capital Benefits

Loss of Income

HOW MUCH CAN I CLAIM?

The following table outlines the various levels of cover within this Program.

NON-MEDICARE MEDICAL COSTS	DEATH & OTHER CAPITAL BENEFITS		LOSS OF INCOME
85% reimbursement	Various capital benefits up to $100,000 maximum.		Up to $500 per week
$5,000 maximum per claim	$100,000 maximum Quadriplegia / Paraplegia events		21 day waiting period
Nil excess per claim *$75 excess per claim (with no PHI)*	$75,000 Death benefit Volunteers	$10,000 Death benefit U/18 & O/65	52 week benefit period

HOW TO LODGE A PERSONAL INJURY CLAIM

1. Complete ALL sections of this form. Your form will be returned if information is missing.
2. Send your completed form to SLE as soon as possible (within 30 days from the injury date). Do not wait until treatment is completed before lodging your claim. Send any invoices for paid non-Medicare medical expenses.
3. SLE will confirm receipt of your claim and provide you with a claim number.
4. Any further costs can be submitted to SLE quoting this claim number.

Documents can be submitted by email or post.

HOW TO SEND COMPLETED FORMS	
Email:	claimsenquiries@sleworldwide.com.au
Post:	SLE Claims Department – PO Box H308, Australia Square, NSW 1215
Phone:	1800 002 676 or 02 9249 4850

IMPORTANT INFORMATION

- You can't claim for any services where you receive a rebate from Medicare.
- Submit only original receipts with your claim form.
- We recommend you retain a copy of all receipts and your claim form for your records.
- Claim through your Private Health Fund first, where possible.

SECTION A - CLAIMANT DETAILS

Claimant's Name:					
Postal Address:					
Occupation:					
Email Address:					
Phone Number:					
Age Category (if racing):					
Date of Birth:		Gender:		☐ MALE	☐ FEMALE
Cycling Aust Member No:					
Membership Details:	☐ RIDE BASIC	☐ RIDE +	☐ RACE	☐ NON RIDING	
Do you have Private Health Insurance?				☐ YES	☐ NO
If YES, what is the name of your Private Health Insurance Provider?					
Private Health Coverage:	☐ DENTAL	☐ HOSPITAL	☐ AMBULANCE	☐ PHYSIOTHERAPY	
Ambulance Membership?				☐ YES	☐ NO
Should a benefit be payable for this claim, please provide your details below for an Electronic Funds Transfer:					
Bank:		Account Name:			
BSB:		Account Number:			

INJURY DETAILS

Date of Injury:		Time of Injury:		☐ AM	☐ PM
Address of where the injury occurred:					
Name of any witness to the injury:					
Address of witness:					
Person to who the accident/incident was reported:					
Date of report:		Time of report:		☐ AM	☐ PM
Describe the accident and how it happened (please attached additional pages if required):					

INJURY DETAILS CONTINUED			
Describe your injury:			
Brief summary of action/treatment taken at the time of the accident/incident:			
Was hospitalisation required?		☐ YES	☐ NO
If yes, please advise name of hospital:			
If admitted to hospital, how long were you there?			
When will you resume WORK/NORMAL ACTIVITIES?			
When will you resume RIDING?			

INJURY RESEARCH DATA (Must be completed to process claim. This information will not affect your claim outcome.)	
Circumstances:	
☐ COMPETING ON A TRACK	☐ RIDING ON PUBLIC ROAD IN A BUNCH (LESS THAN 6)
☐ RIDING SOLO ON PUBLIC ROAD	☐ RIDING ON PUBLIC ROAD IN A BUNCH (6 OR MORE)
☐ COMPETING ON CLOSED CIRCUIT	☐ RIDING SOLO ON PUBLIC ROAD
☐ TRAINING ON CLOSED CIRCUIT	☐ RACING/TRAINING UNDER A UCI LICENSE
☐ RIDING ON BIKE PATH	☐ RIDING ON MTB TRAIL
☐ OTHER	
Club or Recreation: At the time of your accident were you involved in?	
☐ A DIRECT CLUB ORGANIZED ACTIVITY OR;	
☐ YOUR OWN PERSONALLY ORGANIZED ACTIVITY	
☐ A DIRECT PRIVATE PROMOTER RIDE.	
☐ NAME OF PROMOTOR BOX	
☐ NAME OF CLUB BOX	

Did you have bike lights on your bike and operational at the time of incident?	☐ YES	☐ NO	☐ N/A

Injured Person:	☐ RIDER	☐ JUDGE	☐ OFFICIAL	☐ COACH	☐ OTHER

Grade:	☐ SENIOR	☐ JUNIOR	☐ NOT APPLICABLE

Accident description:	
☐ SOLO CRASH	
☐ CAUSED BY/INVOLVED OTHER RIDER	
☐ CAUSED BY/INVOLVED A MOTOR VEHICLE	
☐ CAUSED BY/INVOLVED WALKER, JOGGER OR PEDESTRIAN.	
☐ OTHER	

Weather Conditions: (Tick more than 1 if applicable)	☐ FINE	☐ RAIN	☐ WIND
	☐ EXTREME HEAT	☐ EXTREME COLD	

CLAIMANT DECLARATION

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

1. The injury was sustained accidentally during a cycling activity and is not a pre-existing illness or condition.
2. You have viewed, read and understood the Product Disclosure Statement (PDS) at www.marsh.com/au/financial-services-guide.html
3. You understand that the Health Insurance Act 1973 (Cth) prohibits the 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 Marsh, the insurer and the Claims Managers.
5. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish Marsh'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 Marsh's representatives.

Name of Claimant:	
Signature of Claimant: (Parent or Guardian if under 18 years)	
Date:	

SECTION B - CLUB DETAILS (Only complete if you were injured during a club conducted activity)				
Club Name:				
Club Contact:				
Position within Club:				
Email Address:				
Phone Number:		State:		
Has the Claimant returned to RIDING?			☐ YES	☐ NO
If YES, date Claimant returned?				

CLUB DECLARATION

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

- You are an authorised representative of, and you are acting on behalf of, the Claimant's Club (as above).
- After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.
- You declare the Claimant's injury was sustained accidentally during the cycling activity noted on this form and is not a pre- existing illness or condition.
- The claimant is a registered and financial member of Cycling Australia

Do you have any other comments in relation to this claim?	
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. PROCEED TO SECTION D		
Can you claim compensation from any other policy that includes loss of income benefits? (Such as Workers Compensation, State Traffic Authority)	☐ YES	☐ NO
Have you ever made any previous Loss of Income claims in respect to a personal accident insurance or any other insurance?	☐ YES	☐ NO
Have you engaged in any other income earning employment since you have been injured?	☐ YES	☐ NO

TO BE COMPLETED BY THE CLAIMANTS EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)				
Claimants 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:		
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?		

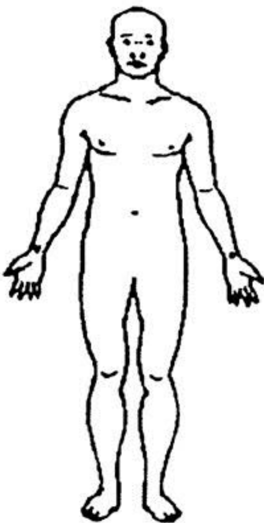
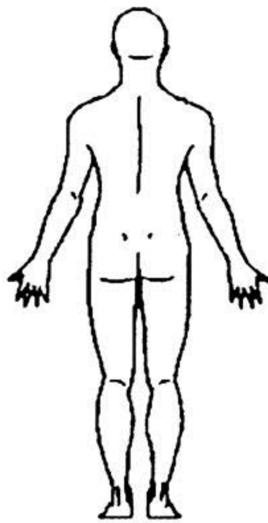
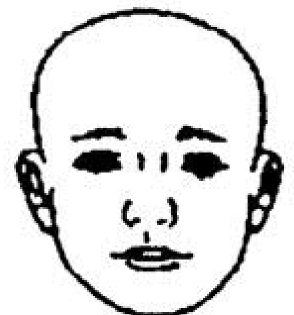
Sick Leave:	☐ YES	☐ NO	From:		To:	
Annual Leave:	☐ YES	☐ NO	From:		To:	
Other:	☐ YES	☐ NO	From:		To:	

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances. Excludes income derived by competing sport.

EMPLOYERS DECLARATION:	
By signing the declaration below, you confirm and agree to the following: • You are the Claimant's current employer (or accountant if the claimant is self-employed), • After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate, • You will supply upon request any further information as required for the determination of this claim.	
Employer's Full Name: * Accountant's name if claimant is self-employed	
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 MARSH OR CYCLING AUSTRALIA This section must be completed (in full) by your attending physician. *An attending physician includes a general practitioner or dentist.*					
Patient's First Name:		Patient's Last Name:			
Physician's Name:		Physician's Phone No.:			
How long have you known the patient?					
Are you the patient's regular practitioner?				☐ YES	☐ NO
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 (**X**) the anatomical location below:

Injury Type:	☐ Amputation	☐ Bruising	☐ Concussion	☐ Cut	☐ Death
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Rupture	☐ Sprain
	☐ Strain	☐ Fatigue/Debilitation			
Do you consider the Claimant's injury to be a NEW injury?				☐ YES	☐ NO

INJURY CONSULTATION CONTINUED		
Do you consider the Claimant's injury to be a recurrence of an old injury?	☐ YES	☐ NO
If YES, please provide details and a description:		
Does the Claimant have any congenital defects or chronic diseases?	☐ 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.		
Chiropractic's:	☐ 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
What date do you advise the Claimant to return to cycling?		

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.

INCAPACITY TO WORK STATEMENT

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: You have examined the Claimant's injury as described on thisform; You declare that all information provided by you and supplied herein is true andaccurate.	
Medical Practitioner's Signature:	
Date:	
For more information, please refer to Marsh's web site www.marsh.com/au/cycling	

MARSH COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Marsh Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Marsh') 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 Marsh 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 (Cth), the Marine Insurance Act 1909 (Cth) 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 Marsh's Associated Entities, which are all businesses of Marsh & McLennan group of companies ('MMC').
- Your personal information may be sent to our administrative processing centres in Mumbai (India) or Kuala Lumpur (Malaysia) and to other MMC 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, you must obtain it with the individual's consent.
- We will use and disclose your personal information in accordance with our Privacy Policy. By completing this form you confirm that you have read the Marsh Privacy Policy available on our website (www.marsh.com.au) and you authorise and consent to Marsh collecting, holding, using and disclosing any personal information collected by means of the enclosed document in accordance with the terms of the Marsh Privacy Policy, including for the purposes explained in this collection statement above. If there are any inconsistencies between the terms of this collection statement and the terms of the Marsh Privacy Policy, the terms of the Marsh Privacy Policy prevail to the extent of that inconsistency. You may modify or withdraw your consent at any time. If you do not give us consent or subsequently modify or withdraw your consent, we may not be able to provide you with the products or services you want.
- You can contact our Privacy Officer by:

  Email – privacy.australia@marsh.com
  Phone – (02) 8864 7688
  Post – PO Box H176, Australia Square NSW 1215

The advice in this form is general advice only. To help you decide if the cover suits you, please read the Product Disclosure Statement. We can provide you with further information. Please contact us to request. This insurance is arranged by Marsh Advantage Insurance Pty Ltd (ABN 31 081 358 303, AFSL 238 369) ('MAI'). MAI are not the insurer.

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