SLE Worldwide Australia Pty Limited
ABN 15 066 698 575 Licence No: 237268
Level 11, 56 Clarence Street, Sydney NSW 2000
PO Box H308, Australia Square NSW 1215
Ph: 1800 002 676 Fax: (02) 9249 4840
www.sleworldwide.com.au

RUGBY LEAGUE CASE REPORT

RUGBY LEAGUE SPORTING ACCIDENT REPORT FORM

IN CASE OF SERIOUS INJURY, CALL 1-800-002676

ABN 15 066 698 575 Licence No: 237268
Level 11, 56 Clarence Street, Sydney NSW 2000 www.sleworldwide.com.au
PO Box H308, Australia Square NSW 1215

This information **must** be completed and signed by the **Injured Person, Club Official and Group Secretary** and forwarded to **SLE Worldwide Australia Pty Limited** within 30 days of injury. **DO NOT** wait for all accounts/receipts before forwarding.

We may be unable to deal with your claim properly if you have not answered all questions fully.

IMPORTANT INFORMATION: PLEASE READ

IMPORTANT NOTE REGARDING CLAIMS FOR MEDICAL EXPENSES

We ***do not provide cover*** for any account that is fully or partially covered by Medicare. This means we do not cover expenses claimable from Medicare or the Medicare Gap. The reason for this is that the National Health Act 1953 does not permit us to do so. Please do not send us any account/receipt that is covered by Medicare or Medicare Statements. Do not wait for any account/receipt before sending.

We ***do cover*** Non Medicare medical expenses. We will pay the percentage amount shown in the Policy schedule of charges for Private Hospital, Dental, Ambulance, Chiropractic treatment, Physiotherapy, or any similar provider of medical services provided always that such treatment is certified necessary by a legally qualified practitioner.

HOW TO CLAIM NON MEDICARE MEDICAL EXPENSES ONLY

When claiming for Non Medicare medical expenses you must have the '***Sporting Accident Report Form***' fully completed.

Medical treatment must be certified necessary by a legally qualified medical practitioner. This could be your treating doctor or dentist. The '***Attending Physician's Statement***' must be fully completed (without expense to the Insurer) prior to submitting a claim.

Please note that non-medicare medical expenses is ***limited for 12 months*** from the date of the accident.

Please check with your Club for exact cover, or phone us on 1800 002 676.

HOW TO CLAIM LOSS OF INCOME

When claiming for Loss of Income you must have the '***Sporting Accident Report Form***' fully completed including the section to be completed by your Employer. If self employed you will need to attach proof of earnings such as a tax return or BAS statement.

The policy has a 28 day Deferral Period (each and every claim) for Senior Players, this means the first 4 weeks off work will not be reimbursed.

The policy has a 14 day Deferral Period (each and every claim) for Junior Players, this means the first 2 weeks off work will not be reimbursed.

You must have your treating doctor complete the '***Attending Physician's Statement***' (without expense to the Insurer) prior to submitting a claim.

Original medical certificates must be forwarded. We do not accept photocopies and the medical certificates must always be current.

If your disability is continuing, please forward medical certificates every four weeks. Loss of income benefits will not be paid until all statements and documents are submitted.

PLEASE REMEMBER

1. If you have Private Health Insurance, you must submit details to your insurer prior to claiming from us.
2. Attach original receipts/accounts for the treatment you are claiming.
3. Excesses and percentages of cover apply under the Policy.

It is suggested that you check these details with your Club or us prior to submitting a claim.

PLEASE RETURN COMPLETED FORMS DIRECTLY TO:

SLE Worldwide Australia Pty Limited
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Level 11, 56 Clarence Street, Sydney NSW 2000
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SLE SM Worldwide Australia Pty Ltd.
Insuring the world's fun SM

Level 11, 56 Clarence Street
Sydney NSW 2000

PO Box H308
Australia Square NSW 1215

ATTENDING PHYSICIAN'S STATEMENT

THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

The "Attending Physician's Statement" must be completed by a qualified medical practitioner such as a Doctor, and not a Physiotherapist, etc.

Reference number: _____ Policy Number (with prefix): _____

Sex: ☐ Male ☐ Female Age: _____

Patient's name and address: _____

What is disabling patient? _____

Please give a complete diagnosis of this condition: _____

_____

_____

_____

HISTORY:

1. When did patient first receive medical treatment? _____
2. (a) Was there a previous history of this or similar condition? ☐Yes ☐No
   (b) If yes, please state condition and advise when previous treatment was given: _____

_____

_____

3. (a) How long have you known the patient? _____

   (b) Are you the regular general practitioner? ☐Yes ☐ No If not, please advise who is: _____

IF INJURY:

1. When did patient suffer the injury? _____

2. What were the circumstances surrounding the injury? _____

IF SICKNESS:

1. When was sickness first contracted? _____

2. When did symptoms become evident? _____

DEGREE OF DISABILITY:

1. Patient's Occupation: _____

2. When was patient obliged to cease work? _____
3. If patient is still disabled, when approximately will the patient be able to resume: (a) Some Duties? _____

   OR (b) Full Duties? _____

4. If patient has recovered, when was patient able to resume: (a) Some Duties? _____

   (b) Full Duties? _____

PLEASE TURN OVER

TREATMENT OF PRESENT CONDITION:

1. When were you consulted? (a) Initially: _____ (b) Most Recently: _____

2. How often has patient consulted you? _____

3. Was patient confined to hospital? ☐ Yes ☐ No

If yes, please advise 1. Name and address of hospital: _____

2. Period of confinement: From: _____ To: _____

4. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No

If yes, give details: _____

_____

5. What are the current subjective symptoms? _____

6. Please give results of any objective findings: _____

1. X-Rays

2. Other tests - please advise tests done and findings: 1. _____

2. _____

7. What surgical procedures have been performed? 1. _____

2. _____

8. What surgical procedures are contemplated? 1. _____

2. _____

9. What other treatment has patient undergone? _____

10. What other treatment is required? _____

Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No

If yes, please advise nature of underlying conditions and how they affect disability and recovery: _____

_____

Has patient any other physical or mental impairment? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please advise names and addresses of other treating physicians: _____

If you have terminated treatment, please advise date: _____

_____

What is the current prognosis? _____

_____

_____

Are there any further remarks which may assist in assessing this condition? _____

_____

_____

_____

Is there any permanent disability at present? ☐ Yes ☐ No

If yes, please explain giving estimated percentage loss of function: _____

_____

_____

_____

Signature: _____ Date: _____ Degree: _____

Name (please print): _____

Street Address: _____

City or Town: _____ State: _____ Phone Number: ( ) _____

SPORTING ACCIDENT REPORT FORM

SLE Worldwide Australia Pty Limited
ABN 15 066 698 575 Licence No: 237268

Please return this form to:

Level 11, 56 Clarence Street, Sydney NSW 2000
PO Box H308, Australia Square NSW 1215
Ph: 1800 002 676 Fax: (02) 9249 4840

Players Name:				Email Address:			
Address:					Post Code:		
Telephone:	Home:		Work:		Mobile:		
Date of Birth:			Height:		Weight:	Sex:	M / F
Normal occupation prior to disablement:							
Name of Club, Grade & Team:			Registration Number:		Position Played:		

DETAILS OF INJURY:

A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).

Type of Injury:			To what part of the Body:								
Place where you were injured:											
Date of Injury:		Time:		Training:	Yes		No		Playing:	Yes		No	
B.1) Have you ever had this, or a similar condition in the past?					Yes		No				
2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if unsufficient space).											
Condition(s):			Date:			Treated By:					
Do you hold Private Health Insurance?	Yes		No		Membership Number and Branch						
Have you claimed yet?	Yes		No		Hospital		Ancillaries		Both		

PROGRAMME:

- ☐ PRESEASON TRAINING
- ☐ PRESEASON TRIAL
- ☐ PRESEASON COMPETITION
- ☐ REGULAR SEASON MATCH
- ☐ FINAL SERIES MATCH
- ☐ 7'S TOURNAMENT
- ☐ OFFICIAL CRL SCHOOLS MATCH
- ☐ GROUP REPRESENTATIVE MATCH
- ☐ DIVISION REPRESENTATIVE MATCH
- ☐ REPRESENTING COUNTRY

PLAYER POSITION:

- ☐ FRONT ROW
- ☐ HOOKER
- ☐ SECOND ROW
- ☐ LOCK
- ☐ HALFBACK
- ☐ 5/8
- ☐ CENTRE
- ☐ WING
- ☐ FULLBACK
- ☐ VOLUNTEER / OFFICIAL
- ☐ COACH / REFEREE

FULL DESCRIPTION OF HOW ACCIDENT HAPPENED:

1. IF SELF-EMPLOYED

Please attach proof of earnings over past 12 months immediately preceding injury (net of business expenses, but before income tax and personal deductions e.g. Tax Return)

Who is your Accountant:

Name: _____

Address: _____

_____

Postcode: _____ Phone Number: ( ) _____

2. IF EMPLOYED AS A WAGE EARNER, TO BE COMPLETED BY YOUR EMPLOYER

I HEREBY CERTIFY THAT _____ has been unable to attend * his/her usual occupation with the Company as a result of * An Injury/Injuries suffered whilst _____ on____/____/____

* He/she has been Incapacitated since ____/____/____ and is * expected to/did resume duties on ____ /____ /____

* His/her average gross weekly income at the date of injury for the 12 months immediately preceding injury. (excluding bonuses, commission, overtime or any other allowances) $ _____ p.w.

During the period of incapacity, he or she received

*$ _____ Normal Pay from____ /____ /____ to____ /____ /____

*$ _____ Sick Pay from____ /____ /____ to____ /____ /____

*$ _____ Workers' Comp from____ /____ /____ to____ /____ /____

*$ _____ Other (please specify) from____ /____ /____ to____ /____ /____

Has been employed since ____/____/____

NAME OF COMPANY: _____

ADDRESS: _____

_____ POSTCODE: _____

SIGNATURE OF SUPERVISOR OR PAYMASTER: _____

NAME OF SUPERVISOR OR PAYMASTER (please print): _____

TELEPHONE NUMBER: ( ) _____ DATE: ____/____/____

***DELETE WHICHEVER NOT APPLICABLE**

TO BE COMPLETED BY CLUB SECRETARY/TREASURER, THEN FORWARD TO GROUP SECRETARY FOR SIGNING.
PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED.

_____ was injured as stated whilst playing

*_____ Grade with the Club on the ____/____/ ____

NAME OF CLUB: _____

SECRETARY/TREASURER'S NAME: _____ DAYTIME CONTACT: ( ) _____

ADDRESS: _____ MOBILE NUMBER: _____

_____ POSTCODE: _____

I HEREBY CERTIFY THAT the particulars shown on this form, are to the best of my belief and knowledge, true and correct.

SIGNATURE: _____ DATE: ____/____/ ____

WITNESS: _____

*INSERT GRADE APPLICABLE: _____ **GROUP SECRETARY:** _____

Insert if applicable in space provided any further information relevant to Insured Player's Injury.

HAS / DID THE PLAYER RETURNED TO PLAY? ☐ YES ☐ NO If YES, what date: ____/____/ ____

If not, please advise this office as soon as the player resumes playing sport.

PTO

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 .....

Players Signature ..... Date ...../...../.....

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

Details of Non Medicare expenses claimed

NB Only forward accounts for services which are not subject to a Medicare rebate
Ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

1. Give full description of injury from which you are now suffering. State when, where and how it happened. 2. (a) Have you ever had this, or a similar condition, in the past? (b) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics.	☐ INJURY HOW SUSTAINED FULL DESCRIPTION:	☐ YES ☐ NO TRAINING ☐ YES ☐ NO COMPETITION OVAL: _____ TOWN/CITY: _____
	☐ YES ☐ NO	CONDITION(S): DATES: TREATED BY:

3. (a) Give exact date when injury occurred: (b) When did you first consult a physician for this condition? (c) When did you become totally disabled (unable to work)? (d) When were you able to again perform part of your occupational duties? (e) When were you able to again perform all of your occupational duties? (f) If still totally disabled, when do you expect your disability to terminate? (g) When will you resume training?	(a) Date: _____ Time _____ ☐ a.m. ☐ p.m. (b) Date: _____ Time: _____ ☐ a.m. ☐ p.m. (c) Date: _____ Time: _____ ☐ a.m. ☐ p.m. (d) Date: _____ Time: _____ ☐ a.m. ☐ p.m. (e) Date: _____ Time: _____ ☐ a.m. ☐ p.m. (f) Date: _____ Time: _____ ☐ a.m. ☐ p.m. (g) Date: _____

4. Hospitals (Give complete names, addresses and dates of admission and discharge).	NAMES	ADDRESSES	FROM TO
5. (a) Give names addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE CONSULTED WHEN?
(b) Give names addresses and telephone numbers of usual family physician.	NAMES	ADDRESSES	TELEPHONE
6. What other medical or surgical treatment has been received duringthe past 5 years? (Give dates, nature of sickness or injury and names and addresses of all treating doctors, hospitals and clinics).	NATURE OF INJURY	NAMES	ADDRESSES
7. Are you now, or have you ever been subject to or affected by any other injury or disease deformity defect of senses infirmity or weakness? If so, give details.			

8. Do you hold Private Health Insurance? ☐ Yes ☐ No	Membership Number and Branch _____	Have you claimed yet? ☐ Yes ☐ No	Hospital ☐ Ancilliaries ☐ Both ☐

ELECTRONIC BANKING DETAILS TO BE COMPLETED BY THE INSURED PERSON

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 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/We shall notify SLE Worldwide Australia Limited of any changes to the above details immediately in writing.

Name (please print): _____

Signed: _____ Date: _____