V-INSURANCE GROUP

Arch

Office use only

Policy Number: _____

Claim Number: _____

BASEBALL AUSTRALIA

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone (02) 8256 1770 Fax (02) 8256 1775
Email claims@csnet.com.au

V-INSURANCE GROUP

INSURANCE BROKER FOR BASEBALL AUSTRALIA;
Authorised Representative No. 432898 a corporate
authorised representative of Willis Australia Limited AFSL: 240600

Phone (02) 8599 8660 or local call cost only 1300 945 547

BASEBALL AUSTRALIA
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death benefit is $100,000 (other than anyone under 18 and over 75 years old $20,000 maximum). The paraplegia and quadriplegia benefit is $250,000 ($20,000 for members aged over 75 years).

Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses up to a maximum of $2,250 ($3,000 for dental) Claimable expenses are private hospital, ambulance, dental etc, net of any recoveries from private health insurance. 100% Ambulance costs reimbursement under this benefit. – Benefit subject to a nil excess for claimants who are covered by private health insurance only claiming ambulance, or otherwise $20. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

Student Assistance Benefit

Reimburses 100% of costs incurred up to a maximum of $400 per week for up to fifty two (52) weeks being costs actually incurred for tutoring, travelling costs, etc, to assist the full-time student – 7 day excess.

Home Help Benefit

Reimburses non-wage earners up to 100% of cost incurred up to a maximum of $400 per week for up to fifty two (52) weeks being reimbursement of actual costs incurred for cooking, ironing, washing, cleaning, child minding expenses as a result of injury, insured by the policy – 7 day excess.

Parents Inconvenience Allowance

Pays up to a maximum of $1,500, whilst the child is hospitalised to offset costs incurred for baby-sitting, taxi fares etc. This benefit is only available for full time students under 25 years of age. The maximum benefit period is fifty two (52) weeks and the policy excess is 7 days.

Loss of Income

Cover for 85% of your net weekly income or up to a maximum of $250 per week, whichever is the lesser. The benefit period is fifty two (52) weeks and the excess is 7 days.

Funeral Benefit

If a death benefit has been paid under capital benefits, an amount of $10,000 is available for reimbursement of funeral expenses.

Important Notes

This insurance cover is underwritten by: Arch Underwriting at Lloyd's (Australia) Pty Ltd
ABN 27 139 250 605 AFSL 426746. Level 4,
68 York Street Sydney NSW 2000

1. This summary of cover provides factual information about the Baseball Australia Insurance Program.
2. This summary of cover provides factual information about the Baseball Australia Insurance Program The policy with full conditions is available at www.vinsurancegroup.com/baseball or by contacting Baseball Australia.
3. This insurance program commenced on 30 November 2020 and expires on 30 April 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Baseball Australia who, through injury or accident, incur financial loss and who would not have otherwise received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance.
5. Baseball Australia are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the Baseball Australia insurance program can be obtained by visiting

http://www.vinsurancegroup.com/baseball

HOW TO MAKE A CLAIM

Dear Baseball Australia (BA) member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. Failure to complete all sections of this form properly may delay settlement of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

2. Please ensure that you fully complete pages 4, 5 & 6 and sign and date the Declaration.

3. For claims involving Loss of Income:

a) You must complete page 8 and have your employer/salary officer to complete page 8. If self employed, you must have your accountant complete these details;

b) You must complete the Tax File Declaration form on page 9. If you are employed and pay tax on the income you earn (known as PAYE), the ATO requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be forwarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.

c) Have your Attending Physician or Physiotherapist complete the page titled "Doctor's Statement" on pages 11 and 12.

4. For claims involving Non-Medicare medical expenses:

a) Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist).

b) Have your Attending Physician complete the "Attending Physician" statement on page 12.

5. Please attach all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital room and theatre fees, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

6. Once you have completed all sections of the claim form, please have your Club and State Association complete and sign page 4 & 5 confirming that your injury occurred during a sanctioned activity.

7. Once you have completed your claim form, please forward to Corporate Services Network. They handle all claims for the insurer. Their contact details are as follows;

Corporate Services Network
GPO Box 4276
Sydney NSW 2001
Phone (02) 8256 1770
Fax (02) 8256 1775
Email claims@csnet.com.au

8. Your reimbursement cheques will be sent to you directly by Corporate Services Network.

9. Once your claim is registered, you can submit ongoing invoices via Corporate Services Network. Corporate Services Network can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

10. If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the V-Insurance Group Team on ph: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Claimant's Given Name:	Surname:		Member No (if applicable):
Name of Association:	Name of Club / League:	Name of team/age group/grade:	
Occupation:	Date of Birth: / /	Gender (please tick): ❑ Male ❑ Female	Email:
Address		State	Postcode
Phone Number (work): ( )	Home ( )	Mobile	

Please tick the category applicable ❑ Player ❑ Official ❑ Coach ❑ Umpire ❑ Other

If Other, please advise _____

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I (insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Corporate Services Network to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Corporate Services Network and their service providers in order to assess the claim. Corporate Services Network complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant _____ Date_____

(or Legal Guardian if under 18 years of age)

DECLARATION BY CLUB

Name of Club:	Name of Club Official making this statement:
Official Position:	Telephone Number: ( ) Email:

I, the above mentioned Baseball Australia Club Official, confirm that the claimant was a registered and Financial member of the Baseball Australia Club and confirm that the claimant was taking part in an insured activity as defined by the Personal Accident Insurance with Baseball Australia at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ❑ Yes ❑ No

If yes, please detail _____

_____

Dated: / /	Signature of Club Official:

DECLARATION BY STATE ASSOCIATION

Name of State Association:	Name of State Association Official making this statement:
Official Position:	Telephone Number: ( ) Email:
Address	State Postcode

I, the above mentioned Baseball Australia Official, confirm that the claimant was a registered and Financial member of Baseball Australia and was an insured person as identified in the Personal Accident Insurance with Arch Underwriting at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Do you have any comments in relation to this claim? ❑ Yes ❑ No

If yes, please detail _____

_____

Dated: / /	Signature of State Association Official:

Office use only

Policy Number: _____

Claim Number: _____

ACCIDENT DETAILS

Describe the accident and how it happened? _____

_____

_____

Describe your injury?

When did your accident occur?

Date: / / Time: am/pm

Was your activity at the time of the accident? (please tick)	Officially organised competition	❑
	Officially organised training	❑
	Social or private competition	❑
	Travelling to and from activity	❑
	Sanctioned fundraising/social event	❑

Please provide the address of where the injury occurred:

State the name of any one witness to the injury:	Address of witness:
Person to whom accident/incident was reported?	Date and time reported? Date: / / Time: am/pm

Brief summary of treatment/action taken at the time of the accident/incident:

Was hospitalisation required?	If yes, please advise the name of hospital:
If admitted into hospital, how long were you there?	Name of person who gave treatment?
Do you have Private Health Insurance?	If yes, please give fund name:

Advise when you did (or expect to):	Cease work/normal activities _____
	Cease training _____
	Cease participating _____
	Resume work/normal activities _____
	Resume training _____
	Resume participating _____

Have you ever had this injury or similar injuries in the past?	If yes, please advise when: / /

The following information is required for Baseball Australia research to assist with Risk Management. <u>Answering these questions will not affect your claim.</u>		
Surface at point of injury? (please tick)	Grass	❑
	Astroturf / Synthetic Grass	❑
	Other, please advise……	❑
Weather conditions? (please tick)	Fine	❑
	Rain	❑
	Showers	❑
	Extreme Heat	❑
	Extreme Cold	❑
What were you doing when the accident occurred?	Batting	❑
	Fielding	❑
	Catching	❑
	Running Bases	❑
	Warming Up	❑
	Other	❑

LOSS OF INCOME
(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME)

(Please tick the box)	YES	NO
1. Can compensation be claimed under Workers Compensation or any other insurance or any other insurance including Loss of Income?		
2. Have you ever made any previous claims in respect to personal accident insurance or any other insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR EMPLOYER / SALARY OFFICER.
IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNTANT COMPLETE THESE DETAILS.

Name of employer:	Telephone Number: ( ) Fax Number: ( )
Address of employer: State Postcode	
Date ceased work due to injury: / /	Date expected to resume normal duties: / /
Employee weekly salary as at date of injury: Net $..... Gross $..... If self employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.	Date commenced employment with company: / /

Income Definition:

❑ Self Employed ❑ Full Time ❑ Part Time ❑ Casual

During the period of incapacity the employee has received

$.....	Normal Pay	From	……/……/……	to	……/……/……
$.....	Sick Pay	From	……/……/……	to	……/……/……
$.....	Workers Compensation	From	……/……/……	to	……/……/……
$.....	Other (please specify)	From	……/……/……	to	……/……/……

Has the employee returned to work? ❑ Yes ❑ No

Has the employee lodged or intending to lodge a Workers Compensation Claim? ❑ Yes ❑ No

A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

Accountant's name:	Phone Number: ( )
Accountant's signature: Accountant's Company Stamp:	Date: / /

Australian Government
Australian Taxation Office

ato.gov.au

Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
- Print **X** in the appropriate boxes.
- Read all the instructions including the privacy statement before you complete this declaration.

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 3, 3b)

Section A: **To be completed by the PAYEE**

1 What is your tax file number (TFN)?

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN. ☐

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax. ☐

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance. ☐

2 What is your name? Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname or family name

First given name

Other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

4 What is your date of birth? Day / Month / Year

5 What is your home address in Australia?

Suburb/town/locality

State/territory Postcode

6 On what basis are you paid? (Select only one.)

Full-time employment ☐ Part-time employment ☐ Labour hire ☐ Superannuation or annuity income stream ☐ Casual employment ☐

7 Are you an Australian resident for tax purposes? (Visit **ato.gov.au/residency** to check) Yes ☐ No ☐

8 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Yes ☐ No ☐ Answer **no** here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions. No ☐

10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Yes ☐ Complete a *Withholding declaration* (NAT 3093). No ☐

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

(b) Do you have a Financial Supplement de

Yes ☐ Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. No ☐

DECLARATION by payee: *I declare that the information I have given is true and correct.*

Signature — You MUST SIGN here

Date: Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Once section A is completed and signed, give it to your payer to complete section B.

Section B: **To be completed by the PAYER** (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number?

30 074 864 609

Branch number (if applicable) 004

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes ☐ No ☐

3 What is your legal name or registered business name (or your individual name if not in business)?

CORPORATE SERVICES

4 What is your business address?

Suburb/town/locality: SYDNEY

State/territory Postcode

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 02 8256 1770

6 If you no longer make payments to this payee, print X in this box. ☐

DECLARATION by payer: *I declare that the information I have given is true and correct.*

Signature of payer

Date: Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Return the completed original ATO copy to:
Australian Taxation Office
PO Box 9004
PENRITH NSW 2740

IMPORTANT
See next page for:
- payer obligations
- lodging online.

Sensitive (when completed)

30920716

NON MEDICARE MEDICAL EXPENSES

(ONLY COMPLETE THIS SECTION IF CLAIMING FOR THESE EXPENSES)

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap).

Are you a member of an Ambulance Service? ❑ Yes ❑ No

Are you a member of a Private Health Fund? ❑ Yes ❑ No

If yes, please provide details .....

Hospital Cover? ❑ Yes ❑ No

Extra's covering, Physio etc ❑ Yes ❑ No

Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

NAME OF PROVIDER	NATURE OF SERVICE E.G DENTAL PHYSIOTHERAPY ETC	DATE OF SERVICE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	AMOUNT CLAIMABLE
				Total	
				Less Excess	
				TOTAL AMOUNT OF CLAIM	

If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:

Name of Doctor:.....

Address:.....

V-INSURANCE GROUP

Office use only
Policy Number:.....
Claim Number: .....

AR No. 432898 Willis Australia Limited AFSL: 240600
Phone (02) 8599 8660 or local call cost only 1300 945 547
Completed claim forms should be sent to
Corporate Services Network, GPO Box 4276 Sydney NSW 2001
or via email claims@csnet.com.au

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

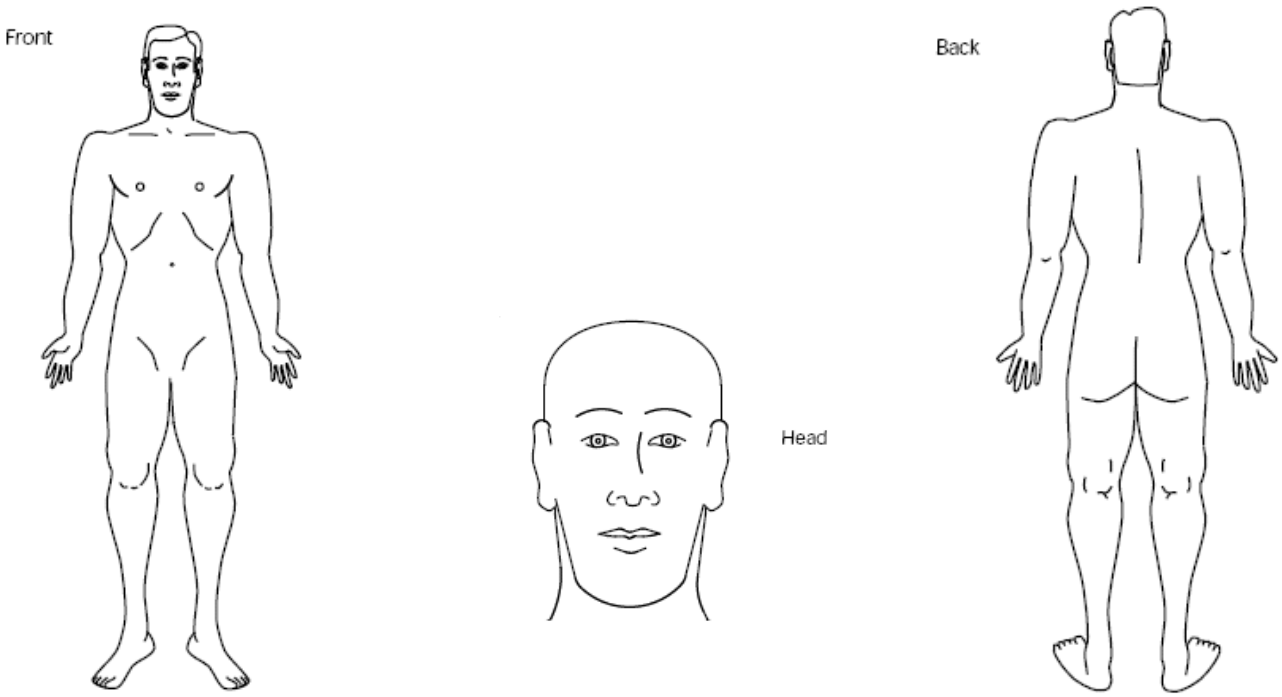
DOCTOR'S STATEMENT
(PLEASE PRINT LEGIBLY)

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.**
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Full Name:	How long have you known the patient?
Patient's Occupation:	
What date and where were you first consulted by the patient in connection with the present injury? / /	
Are you the patient's regular general practitioner? ❑ Yes ❑ No If not, please advise who is	
What is the exact nature of the present injury?	



Do you consider the patient's injury to be a new injury? ❑ Yes ❑ No

A recurrence of an old injury? ❑ Yes ❑ No

If yes, please state condition and advise when previous treatment was given .....

.....

Have you referred the patient to any other services or treatment? ❑ Yes ❑ No

Please specify the type and approximate number of treatments required:

❑ Physiotherapy .....

❑ Chiropractic .....

❑ Other .....

Have any surgical procedures been performed? If yes, please specify .....

.....

What surgical procedures are contemplated? .....

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 .....

.....

Was the patient obliged to cease work? ❑ Yes ❑ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient to return to baseball? .....

Does the patient have any congenital defects or chronic diseases? ❑ Yes ❑ No

If yes, please give dates, name of treating doctor and describe .....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: ..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature: ..... Qualifications: .....

Date: .....

METHOD OF PAYMENT

Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account

Please indicate your preferred method of payment (please tick) ❑ Cheque ❑ EFT

If you would like your payment made by EFT, please complete the details below.

NAME OF CLAIMANT

Title: ❑ Mr. ❑ Mrs ❑ Ms ❑ Miss

Name:_____

BANK ACCOUNT DETAILS

BSB number (all 6 digits are required here) Account Number

❑❑❑❑❑❑ ❑❑❑❑❑❑❑❑❑

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch:_____

DECLARATION

I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply:

- I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment.
- Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network' s disclosure of this information, to Corporate Services Network's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the *Privacy Act 1988.* I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account.
- I declare that the details in this application are true and correct and (where applicable) I am authorised on behalf of the Company to provide the information above.
- I agree that my personal information may also be shared with Baseball Australia's insurance brokers, V-Insurance Group.

Signature: _____ Date: _____

Print Name: _____