V-INSURANCE GROUP
CORPORATE AUTHORISED REPRESENTATIVE OF WILLIS

Office use only
Policy Number:
Claim Number: _____

MOUNTAIN BIKE AUSTRALIA

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PERSONAL INJURY CLAIM FORM

INSURANCE BROKER FOR MOUNTAIN BIKE AUSTRALIA INC;

V-Insurance Group Pty Ltd
Authorised Representative No. 432898
a corporate authorised representative of
Willis Australia Limited AFSL: 240600
Level 28, 123 Pitt Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547
Fax (02) 8599 8661
Email: sports@vinsurancegroup.com

CLAIM FORMS ARE TO BE SENT TO;

Mountain Bike Australia
PO Box 377, Varsity Lakes
QLD, 4227
Phone (07) 5628 0110
Email info@mtba.asn.au

Important Notes

This insurance cover is issued by: Pen Underwriting Pty Ltd
ABN 89 113 929 516 AFSL 290518 as Coverholder on behalf of certain Underwriters at Lloyd's
Level 19, 347 Kent Street Sydney NSW 2000

1. This summary of insurance cover provides factual information about the Mountain Bike Australia Insurance Program as contained in the Product Disclosure Statement (PDS). Cover is subject to the full terms, conditions and exclusions contained in the PDS. Certain terms used in this summary are defined in the PDS.
2. This insurance program commenced on 30 November 2016 and expires on 30 November 2017.
3. V-Insurance facilitates this insurance program which provides benefits to those registered members of Mountain Bike 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.
4. Mountain Bike 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 Mountain Bike Australia insurance program can be obtained by visiting www.vinsurancegroup.com/mtba

HOW TO MAKE A CLAIM

Dear Mountain Bike Australia member,

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed as truthfully and accurately as possible. 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 Declarations.

3. Please ensure that your Club official completes and signs the Club Declaration on page 4.

4. For claims involving Loss of Income:

a) You must complete page 6 and have your employer/salary officer complete page 6. If self employed, you must have your accountant complete these details;

b) Have your Attending Physician complete the page titled "Doctor's Statement" on page 11.

5. 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 11 & 12.

6. 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 the insurer 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 bed 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.

7. Once you have completed all sections of the claim form, please have your Club complete and sign the declaration on page 4.

8. Once you have completed your claim form. please forward with all relating documentation and receipts to Mountain Bike Australia at the following address;

Mountain Bike Australia
PO Box 377, Varsity Lakes
QLD, 4227
Phone (07) 5628 0110
Email info@mtba.asn.au

9. Mountain Bike Australia will then forward your completed claim form and relating documentation directly to Gallagher Basset Services as agents of PEN Underwriting Pty Ltd. Your reimbursement cheque will be sent to you directly by Gallagher Basset Services. Once your claim is registered, you can submit ongoing invoices via Gallagher Basset Services. Gallagher Basset Services can also be reached on 07 3005 1705 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, please do not hesitate to call the V-Insurance Group Team on: (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

CLAIMANT DETAILS

Claimants Given Name:	Surname:	
Name of Club:	Age group/grade:	Member No (if applicable):
		Member Type(Tick One): Race: Recreation : Free Trial : Non – Riding:
Occupation:	Date of Birth: / /	Gender (please tick): ☐ Male ☐ Female
Email:		
Address	State	Postcode
Phone Number (work): ( )	Home ( )	Mobile

Please tick the category applicable ☐ Rider ☐ Official ☐ Coach ☐ Other

If Other, please advise _____

DECLARATION BY CLUB

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

I, the above mentioned Mountain Bike Australia Club Official, confirm that the claimant was a registered and Financial member of Mountain Bike Australia and confirm that the claimant was taking part in an insured activity as defined by the Personal Accident Insurance with Mountain Bike 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 MOUNTAIN BIKE AUSTRALIA

Name of Moutain Bike Australia Official making this statement:	Member Status
Official Position:	Telephone Number: ( ) Email:
Address	State Postcode

I, the above mentioned Mountain Bike Australia Official, confirm that the claimant was a registered and Financial member of this Mountain Bike Australia and was an insured person as identified in the Personal Accident Insurance with PEN Underwriting Pty Ltd 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.

Dated: / /	Signature of Moutain Bike Australia 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	( )
	Club Training	( )
	Individual Training	( )
	Travelling to and from activity	( )
	Sanctioned fundraising/social event	( )
	Other: _____	
At the time of the accident were you:	Representing Australia at Olympic Games	( )
	Representing Australia at Commonwealth Games	( )
	Representing a listed UCI WorldTour Team	( )

If your accident occurred whilst you were competing in any other event, please provide the name of the 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 Mountain Bike Australia research to assist with Risk Management. Answering these questions will not affect your claim.

Surface at point of injury? (please tick)	Road	( )
	Bike Path	( )
	Dirt/Gravel	( )
	Velodrome	( )
	Other: _____	
Weather conditions? (please tick)	Fine	( )
	Rain	( )
	Showers	( )
	Extreme Heat	( )
	Extreme Cold	( )

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: 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 officers name:	Phone Number: ( )
Salary officers signature: Company Stamp:	Date: / / ABN/ACN:

B. IF SELF EMPLOYED

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

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:.....

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 ☐ 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 Gallagher Bassett Services Pty Ltd 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 Gallagher Bassett Services has instructed its bank to credit the nominated account and that we release Gallagher Bassett Services from any further liability in relation to this payment.
- Gallagher Bassett Services 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 Gallagher Bassett Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Gallagher Bassett Services's disclosure of this information, to Gallagher Bassett Services'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.

Signature: _____ Date: _____

Print Name: _____

TO BE COMPLETED BY THE CLAIMANT

Privacy Statement

Gallagher Bassett Services is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). Gallagher Bassett Services will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs. PEN will take all reasonable steps to ensure that personal information held by Gallagher Bassett Services is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

Gallagher Bassett Services has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information.

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority And Declaration

I understand that by investigating my claim or by accepting proof of my claim, Gallagher Bassett Services has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Gallagher Bassett Services using and disclosing my personal information pursuant to Gallagher Bassett Services's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Gallagher Bassett Services's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to Gallagher Bassett Services such personal information (including health information) as Gallagher Bassett Services in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to Gallagher Bassett Services in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, Gallagher Bassett Services may not be able to process or assess my claim.

I appoint Gallagher Bassett Services to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

I agree that my personal information may also be shared with Mountain Bike Australia's insurance brokers, V-Insurance Group.

Signature of Claimant:		**Dated:**	
Name of Claimant			
Signature of Witness:		**Dated:**	
Name of Witness:			

V-INSURANCE GROUP

Authorised Representative No. 432898
a corporate authorised representative of
Willis Australia Limited AFSL: 240600
Level 28, 123 Pitt Street, SYDNEY NSW 2000
Phone (02) 8599 8660 or local call cost only 1300 945 547
Fax (02) 8599 8661
Email: sports@vinsurancegroup.com

Office use only
Policy Number:
Claim Number: _____

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 Doctor / Specialist Doctor.**
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

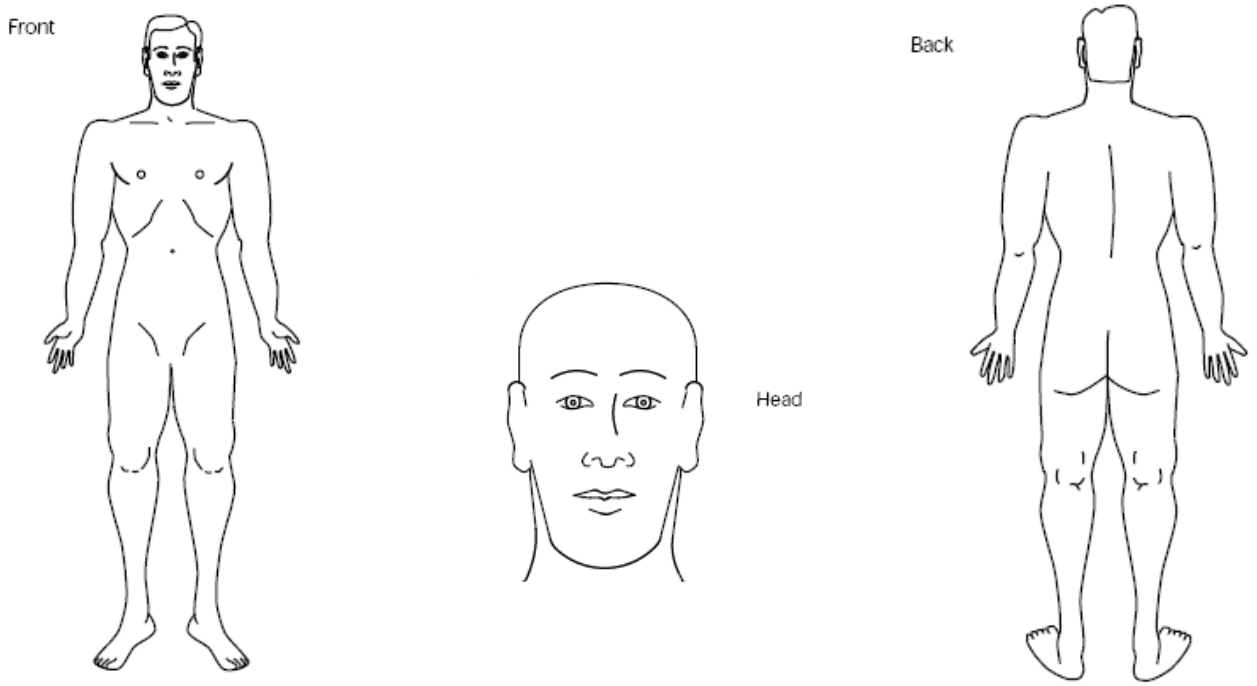
Patient's Full Name:	How long have you known the patient?

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 patients 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 Cycling? .....

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: .....