Echelon Claims Services is a division of Echelon Australia Pty Ltd ABN 96 085 720 056
Address: GPO Box 1693, Adelaide South Australia 5001
Ph (08) 8235 6455 Free call 1800 640 009 Facsimile (08) 8235 6450

PERSONAL INJURY CLAIM FORM

WHO SHOULD COMPLETE THIS CLAIM FORM?

You should complete this form if:

- ✓ You are a Member – e.g. player, umpire, official or volunteer; and
- ✓ You have sustained an injury –whilst participating in a sanctioned club activity/event; and
- ✓ You have incurred costs – Non-Medicare medical costs

WHAT IS COVERED & HOW MUCH CAN I CLAIM?

Non-Medicare Medical Costs (NB: there is no cover for Medicare Expenses, including the Medicare Gap)
Loss of Income
Death & other Capital Benefits
Please refer to https://au.marsh.com/sport/cricket-australia.html for information about cover.

HOW TO LODGE A PERSONAL INJURY CLAIM?

1. Complete ALL sections of this form
2. Send your completed form to Echelon Australia Pty Ltd (Echelon) as soon as possible (and within 270 days from the injury date)
3. Echelon will confirm receipt of your claim and provide you with a claim number
4. Any further costs can be submitted to Echelon quoting this claim number
5. Documents can be submitted by email or post

HOW TO SEND CLOMPLETED FORMS?

Email:	sportsclaims@echelonaustralia.com.au
Post:	Echelon Claims Services GPO Box 1693 Adelaide SA 5001

IMPORTANT INFORMATION

- You can't claim for any services where you receive a rebate from Medicare
- 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'S DETAILS				
Claimant's Name:				
Address:				
Address:			Postcode:	
Occupation:				
Phone Number:				
Email Address:				
Date of Birth:				
Gender:	☐ Male	☐ Female	☐ Other	☐ Prefer not to say
Date of Injury:				
Time of Injury:	☐ AM	☐ PM		
Club Name:				
Association Name:				
Describe your injury and how it happened (please attach additional pages if required):				

INJURY RESEARCH DATA				
Activity:	☐ Playing	☐ Training	☐ Travelling	☐ Warm up / down
	☐ Other, please describe			
Location:	☐ Indoor	☐ Outdoor		
Inured Person:	☐ Player	☐ Umpire	☐ Official	☐ Trainer
	☐ Other, please describe			
Grade:	☐ Senior	☐ Reserve	☐ Junior	☐ Not applicable
Division:				
Playing Position:	☐ Batting	☐ Bowling	☐ Fielding	☐
	☐ Umpiring	☐ Wicket keeping		
Surface Type:	☐ Grass	☐ Synthetic grass	☐ Asphalt	☐ Concrete
	☐ Indoor	☐ Timber		
Weather Conditions:	☐ Fine	☐ Rain	☐ Extreme heat	☐ Extreme cold
Surface Conditions:	☐ Wet	☐ Dry	☐ Muddy	☐ Indoor

RESUMPTION DATES
When will you resume WORK?
When will you resume TRAINING?
When will you resume PLAYING?

PRIVATE HEALTH INSURANCE				
Do you have Private Health Insurance?			☐ Yes	☐ No
If Yes, what is the name of your Private Health Insurance provider?				
Private Health Coverage:	☐ Dental	☐ Physiotherapy	☐ Ambulance	☐ Hospital
Do you have Ambulance Membership?			☐ Yes	☐ No

PAYMENT DETAILS	
EFT Payee Details:	
Bank:	Account Name:
BSB:	Account Number:

CLAIMANT DECLARATION

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

a. The injury was sustained accidentally during a club activity and is not a pre-existing illness or condition.

b. You have viewed, read and understood the Product Disclosure Statement (PDS) at https://au.marsh.com/sport/cricket-australia.html.

c. You understand that the Health Insurance Act 1973 (Cth) prohibits the Trustee and Insurer from reimbursing Costs that are covered by Medicare (including the Medicare Gap).

d. You acknowledge and agree to the information contained herein (including personal information) being shared with authorised members of JLT Risk Solutions (JLT), the insurer, the Trustee and the Claims Managers.

e. You authorise any hospital, physician or other person who has attended to your injury, or any employer, to furnish JLT'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.

f. You agree that a photocopy or electronic version of this authorisation shall be considered as effective and valid as the original.

g. 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 thereunder for past or future injuries shall be forfeited.

h. You authorise any and all information regarding claims with any other insurer/product issuer to be released to JLT's representatives.

Claimant's Signature*: **Parent or Guardian if under 18 years*	
Date:	

SECTION B – CLUB DETAILS	
Name of Club Contact:	
Position within Club:	
Phone Number:	
Email Address:	
Club Name:	
Association Name:	

REGISTRATION DETAILS		
Is the Club Registered for this Period of Cover?	☐ Yes	☐ No
Loss of Income Cover:	☐ Yes	☐ No
Per week $		

INJURY DETAILS		
Date of Injury:		
Time of Injury:	☐ AM	☐ PM
Opposition Club Name:(if applicable)		
Ground/Location:		
Address:		
Address:	Postcode:	
Has the Claimant returned to TRAINING?	☐ Yes	☐ No
If YES, date Claimant returned?		
Has the Claimant returned to COMPETITION?	☐ Yes	☐ No
If YES, date Claimant returned?		

CLUB DECLARATION

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

a. You are an authorised representative of, and you are acting on behalf of, the Claimant's Club or Association (as above).

b. After reasonable inquiry, you confirm the injury details supplied herein are true and accurate.

c. You declare the Claimant's injury was sustained accidentally during the club activity noted above and is not a pre-existing illness or condition.

d. You understand that registering your club with the endorsed sporting association platform as required by the Club or Association is required for each Period of Cover.

e. You confirm the club's level of cover as per the details provided above.

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? If No, please proceed to SECTION D	☐ Yes	☐ No
Can you claim compensation from any other policy/cover that includes loss of income benefits (such as Workers Compensation)?	☐ Yes	☐ No
Have you ever made previous claims in respect to a personal accident insurance policy/cover or plan?	☐ Yes	☐ No
Have you engaged in any income earning employment since you became injured?	☐ Yes	☐ No

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)				
Claimant's Name:				
Employer/Company Name:				
Contact Person:				
Postal Address:				
State:		Postcode:		
Email Address:				
Phone: (bus hours)		Mobile:		
Employment Status:	☐ Full Time	☐ Part Time	☐ Casual	☐ Self Employed

EMPLOYMENT DETAILS
Employee's NET weekly salary $
Employee's GROSS week salary $
Date Employee commenced with company.
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:
Date expected to resume duties:

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

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 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:
For more information, please refer to: https://au.marsh.com/sport/cricket-australia.html

SECTION D – PHYSICIAN'S REPORT

This section must be completed (in full) by your attending physician and without expense to Marsh / JLT / Echelon.

An attending physician includes a general practitioner, physiotherapist, chiropractor or dentist.

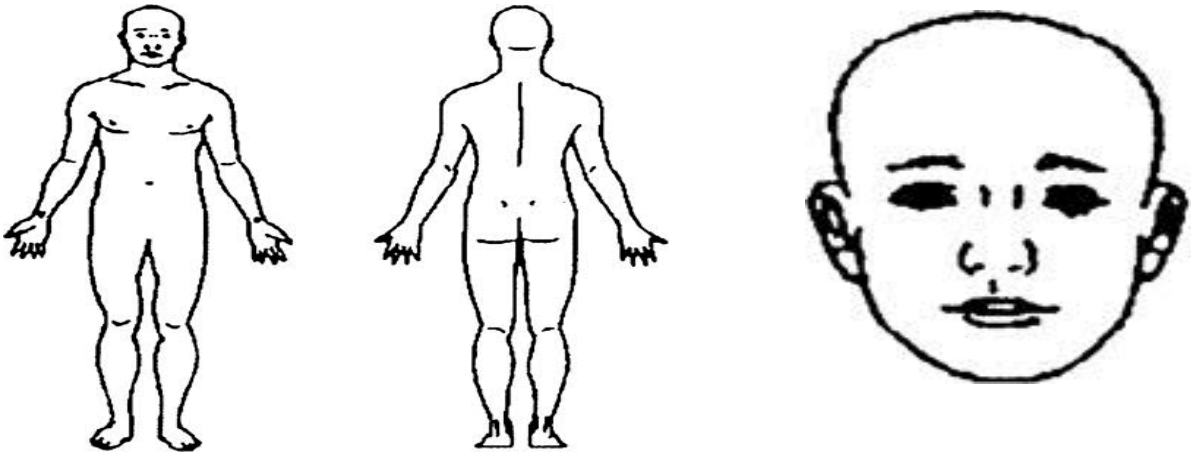
Important: Please print legibly as this form cannot be accepted otherwise.

Claimant's Name:	
Physician's Name:	
Phone Number:	
Email Address:	
Date of Injury:	
Date of Consultation:	

Please provide a 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
	☐ Dental	☐ Dislocation	☐ Fracture/Break	☐ Death
	☐ Rupture	☐ Sprain	☐ Strain	☐ Fatigue/Debilitation

FIRST MEDICAL TREATMENT	
Date of treatment:	
Name of attending physician:	
Do you consider the Claimant's injury to be a NEW injury?	☐ Yes ☐ No
Do you consider the Claimant's injury to a recurrence of a previous 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:	☐ 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 playing Cricket?	

PHYSICIAN'S DECLARATION

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

a. You have examined the Claimant's injury as described on this form;

b. You declare that all information provided by you and supplied herein is true and accurate.

Physician's Signature:	
Date:	

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 — Examination Date

In my opinion, this person is/has been unfit to work from _____ to _____ inclusive
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:

a. You have examined the Claimant's injury as described on this form;

b. You declare that all information provided by you and supplied herein is true and accurate.

Medical Practitioner's Signature:	
Date:	

ECHELON COLLECTION STATEMENT

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments) ('the Privacy Act'), we, Echelon Australia Pty Ltd and our Associated Entities (as that term is defined in the Corporations Act 2001 (Cth)) ('Echelon') 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