V-INSURANCE GROUP

Pen underwriting

Office use only
Policy Number: _____
Claim Number: _____

BICYCLE NSW

bicycle NSW

PERSONAL INJURY CLAIM FORM

Completed claim forms must be sent to;

Fullerton Health Corporate Services
Level 10, 33 York Street
Sydney NSW 2000
Phone (02) 8256 1770 Fax (02) 8256 1775
Email claims@fullertonhealthcs.com.au

V-INSURANCE GROUP

INSURANCE BROKER FOR BICYCLE NSW;
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

BICYCLE NSW
SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

The scale of benefits is defined in the policy. Members – Death Benefit (18-65 years of age) $50,000. Death Benefit (under 18 – over 65 years of age) $25,000. Volunteers – Death Benefit (18-100 years of age). The paraplegia and quadriplegia benefit is $100,000.

Non Medicare Medical Expenses

Reimburses up to 85% of Non-Medicare medical expenses up to a maximum of $7,500. Some claimable expenses include but are not limited to are private hospital, ambulance, dental, net of any recoveries from private health insurance – subject to a nil excess for claimants who are covered by private health insurance or $50 for claimants who do not have private health insurance. Cover is limited to expenses incurred within twelve (12) months from the date of injury.

Student Assistance Benefit (Full time students)

Reimburses 100% of costs incurred up to a maximum of $200 per week for up to 52 weeks being costs actually incurred for tutoring 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 $200 per week for up to 52 weeks, being reimbursement of actual costs of hiring domestic help and/or child-minding services as a result of injury, insured by the policy – 7 day excess.

Parents Inconvenience Allowance

Pays up to $200 per week of non medical expenses such as transportation and accommodation costs. This benefit is only available for full time students under 25 years of age. The maximum benefit period is 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 $1,000 per week, whichever is the lesser. The benefit period is 52 weeks and the excess is 14 days.

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 of Lloyd's.
Level 19, 347 Kent Street Sydney NSW 2000

1. This summary of insurance cover provides factual information about the Bicycle NSW insurance program.
2. The policy with full terms, conditions and exclusions is available at http://www.vinsurancegroup.com/bicyclensw or by contacting Bicycle NSW.
3. This insurance program commenced on 1 July 2019 and expires on 1 July 2020.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of Bicycle NSW 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. Bicycle NSW is not and does not represent itself as a registered insurance broker by endorsing the products outlined in this claim form.

Further details on the Bicycle NSW insurance program can be obtained by visiting

http://www.vinsurancegroup.com/bicyclensw

HOW TO MAKE A CLAIM

Dear Bicycle NSW 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 and sign and date the Declaration.

3. 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) You must complete the Tax File Declaration form on page 7. 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 9 and 10.

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 pages 9 & 10.

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 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.

6. Once you have completed your claim form. please forward with all relating documentation and receipts to Bicycle NSW;

Fullerton Health Corporate Services
Level 10, 33 York Street Sydney NSW 2000
Phone +61 2 8256 1770
Fax +61 2 8256 1775
Email claims@fullertonhealthcs.com.au

7. Once your claim is registered, you can submit ongoing invoices via Fullerton Health Corporate Services (either by email claims@fullertonhealthcs.com.au or post to Level 10, 33 York Street, Sydney NSW 2000). Should you wish to make enquiries relating to the progress of your claim please contact Fullerton Health directly.

8. 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 (02) 8599 8660 or 1300 945 547.

PERSONAL ACCIDENT CLAIM FORM

Claimant's Given Name:		Surname:	
Age group/grade:		Member No (if applicable):	
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 _____			

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 ❑
- Group training ❑
- Individual training ❑
- Travelling to and from activity ❑
- Travelling to or from work ❑
- Sanctioned fundraising/social event ❑
- Bike couriering/riding for fare or reward ❑
- Other: _____

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 Bicycle NSW research to assist with Risk Management. <u>Answering these questions will not affect your claim.</u>	
Where were you at the point of injury? (please tick)	Traffic Lights ❑ Roundabout ❑ Driveway ❑ Intersection ❑ Other: _____
What time of day did your accident occur? (please tick)	Early Morning (5am – 9.30am) ❑ Mid Morning (9.30am – 12pm) ❑ Early Afternoon (12pm – 2.30pm) ❑ Late Afternoon (2.30pm to 5pm) ❑ Early Evening (5pm – 8pm) ❑ Later:_____
What type of Accident? (please tick)	Solo ❑ Claimant (You) hit a motor vehicle ❑ Motor Vehicle hit claimant (You) ❑ Another bicycle was involved ❑ Other: _____
What were the road conditions? (please tick)	Slippery/Wet ❑ Dry ❑ Dirt/Gravel ❑ 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

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)

ato.gov.au

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)?

FULLERTON HEALTH CORPORATE SERVICES

4 What is your business address?

LEVEL 10

33 YORK STREET

Suburb/town/locality

SYDNEY

State/territory Postcode 2000

5 Who is your contact person?

ANTHONY ROUHANA

Business phone number 0282561770

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 Fullerton Health
Corporate Services, Level 10, 33 York Street, Sydney NSW 2000
or via email claims@fullertonheathcs.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 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

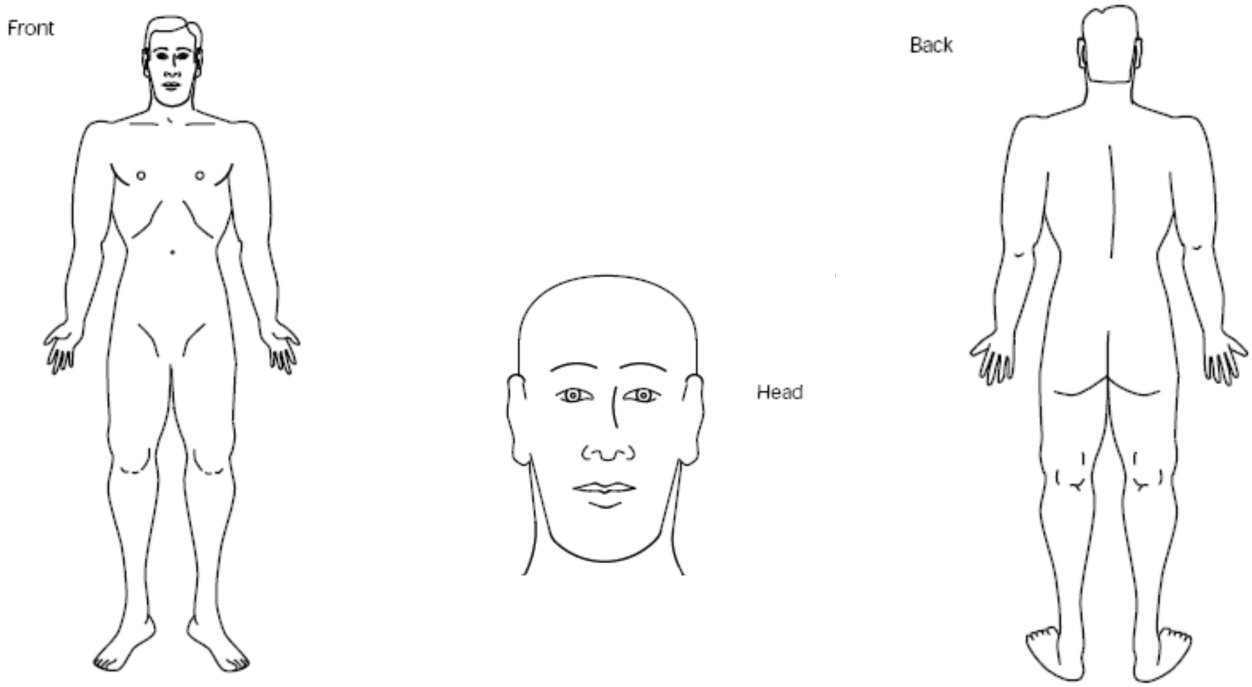
Patient's Full Name:	How long have you known the patient?

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: .....

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 Fullerton Health Corporate Services 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 Fullerton Health Corporate Services has instructed its bank to credit the nominated account and that we release Fullerton Health Corporate Services from any further liability in relation to this payment.
- Fullerton Health Corporate 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 Fullerton Health Corporate Services collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Fullerton Health Corporate Services' disclosure of this information, to Fullerton Health Corporate Services' 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: _____