Karting Australia | Sports Injury claim form

Return completed form to:
Arthur J. Gallagher Co (Aus) Limited
PO Box 852, East Melbourne VIC 3002

Injured: (please tick)

☐ Driver ☐ Crew Member ☐ Pit/Service Crew
☐ Official ☐ Volunteer

Club ______________________
Name: ______________________
Address: ______________________
City: ______________________
State: __________ Postcode: __________
Phone: ______________________
D.O.B: __________ Age: __________
Sex: M ☐ F ☐
Email: ______________________

Event:

Track Name: ______________________
Track City: ______________________
Event Name: ______________________
Event Type: ______________________
Vehicle Type: ______________________
Vehicle Number: ______________________

Injured: (please tick)

Date of injury: ______________________
Injured Body Part: ______________________
Injury Type: ______________________
____
____

(Sprain, Fracture, Concussion etc)

Time

☐ Morning
☐ Afternoon
☐ Evening
☐ Lights

Disposition

☐ On-Site Care Only
☐ Ambulance to Hospital
☐ Fatality
☐ Refused Treatment

Occasion

☐ Morning
☐ Pre-Race Preparation
☐ Qualifying Run/Trials
☐ During Race
☐ During Race/Yellow Flag
☐ Between Races
☐ Non-Race Business

Location

☐ Garage Area
☐ Pits (Entrance) (Exit)
☐ Start/Staging Area
☐ Turn #__________
☐ Straightway
☐ Grandstand
☐ Other __________
____

Activity

☐ Racing
☐ To / From Pits
☐ Vehicle Maintenance Report
☐ Loading / Unloading
☐ Other __________
____
____
____

Situation

☐ Hit by Racer
☐ Hit Racer
☐ Hit Fence/Wall
☐ Hit by Debris (log/rock) (Vehicle part)
☐ Fell (Slip) (Trip) (Pushed)
☐ Other __________
____

Special Circumstances

☐ Lost Wheel
☐ Left ☐ Right ☐ Front ☐ Rear
☐ Stuck Throttle
☐ Wet Track
☐ Other __________
____
____

Estimated Absence from Racing

☐ Less than One Week
☐ One – Three Weeks
☐ More than Three Weeks
☐ Not Applicable

Describe How Accident Happened? ______________________________

____

____

____

____

____

Person who can attest to injury:

Print Name: ______________________ Phone: ______________________

Was there anyone else injured? ______________________________

Treatment

Was hospital treatment required Yes ☐ No ☐ If 'No' – did you visit your GP? If 'Yes' GP details?

Name of Doctor	
Address	

Hospitals – if you were admitted to hospital, or treated as an out-patient, please give details:

	Name	Address	From	To
(a) Inpatient	(a)	(a)	(a)	
(b) Outpatient	(b)	(b)	(b)	

	Name	Address	Telephone Number
Give details of all attending physicians	1.	1.	1.
	2.	2.	2.
	3.	3.	3.

When did you stop work	Time:	am/pm	Date:	
When did you first obtain treatment from a doctor?	Time:	am/pm	Date:	

Name of Doctor	
Address	

Is this Doctor still treating you for the injury? Yes ☐ No ☐ Is this your regular Doctor? Yes ☐ No ☐

If 'No' give details:

Regular Doctors Name				
Address				
		State		Postcode

Is there any injury (past or present) affecting your current disability? Yes ☐ No ☐

If 'Yes' give details:

____

____

____

Are you now:

Recovered		When did you return to work?	____ / ____ / ______
Partially Disabled		When did you return to work?	____ / ____ / ______
Totally Disabled		When do you expect to return to work?	____ / ____ / ______

Have you made, or will you make a claim for benefits under any

Workers Compensation Act or Ordinance because of the injury? Yes ☐ No ☐

If 'Yes', give details	Name	Address
Employer		
Workers Compensation Insurer		

Are you entitled to claim benefits from any Health Fund, Friendly Society?

Yes ☐ No ☐

Name of Fund	Address

If so what benefits will you be claiming? ____________________

____

Have you or will you make a claim for benefits under a Road Traffic Policy (CTP)?

Yes ☐ No ☐

Name of insurer	Address

Employment

If self Employed

Please attach proof of earnings over the past 12 months (e.g. Tax Return or letter from your accountant)

Who is your Accountant?

Name					
Address					
		State		Postcode		Telephone Number

If Employed as a Wage Earner

What are your gross average weekly earnings $ ____________

Please attach proof (e.g. Pay slip (minimum of 4 pay slips required), letter from employer)

Who is your Employer?

Name					
Address					
		State		Postcode		Telephone Number

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.

I authorise any hospital, physician or other person who has attended me to furnish the claims manager any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports.

I authorise that information from this claim form will be made available to Karting Australia through statistical reports

I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Signature of insured Person		Date	____ / ____ / ____
Name of injured person			(Please print)
Occupation of insured person			

Claimants Bank Account details for direct deposit settlements.

Account name			
BSB number		Account number	

N.B. THE MEDICAL CERTIFICATE MUST BE COMPLETED.

Medical Practitioners Statement to Company

THE POLICYHOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT

THIS FORM SHOULD BE COMPLETED AND RETURNED TO ARTHUR J. GALLAGHER PROMPTLY

Patients Full Name		Date of Birth	____ / ____ / ______
	Height: cms ____ Weight: kgs ____		

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

If available please provide a copy of X-ray report

Is this condition an injury ☐ or an illness ☐

Does the patient have any other injury or illness that is contributing to the condition? No ☐ Yes ☐ – give details

Is condition due to injury or sickness arising out of the patients employment? No ☐ Yes ☐ – give details

Was the disability sports related? No ☐ Yes ☐ – give details

Date of onset/first symptoms ____ / ____ / ______

When did the patient first consult you for this condition? ____ / ____ / ______

Has the patient ever had the same or similar condition? No ☐ Yes ☐ – give detail

How long have you been the patients usual doctor/medical practice? ☐ Yrs

Name of patients usual doctor/medical practice

Has the patient had surgery or is it anticipated? No ☐ Yes ☐ – give details

Date performed or anticipated	____ / ____ / ______	**Give name of hospital**	

Did you provide other medical services (including pathology) to the patient? No ☐ Yes ☐ – itemise, give details

Date ____ / ____ / ______	
Date ____ / ____ / ______	
Date ____ / ____ / ______	

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Was the patient referred by you or to you? No ☐ Yes ☐ – give details

Please provide name and address or referring doctor	Name
	Address:
Date of referral	____ / ____ / ______

Is the patient still disabled?

No ☐ – When did the patient return to work? ____ / ____ / ______

Yes ☐ – How long with the patient be:

- totally disabled (unable to perform any part of their occupation)

  from ____ / ____ / ______ to ____ / ____ / ______

- partially disabled (unable to perform any part of their occupation)

  from ____ / ____ / ______ to ____ / ____ / ______

If partially disabled, what duties could the patient perform and for how many hours a week?

	hours per week

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, sports body or any other insurance body?

No ☐ Yes ☐ – give details

Name of company and claim No.	
Contact name and telephone No.	

<u>Remarks</u>

Signature of medical practitioner			
Name – print		Date	____ / ____ / ______
Qualifications			
Address			
Telephone Number			