

**Please return this form to your State Veteran Cycling Office for authorisation and
 They will then forward to QBE Insurance**

Sports Injury Report Form

| | | | | | | | | | | | |
|---|--|--------|--|--------|--|-----|-----|-----------|------|------|--|
| Riders Name | | | | | | | | | | | |
| Address | | | | | | | | Post Code | | | |
| Date of Birth | | Height | | Weight | | Sex | M/F | Telephone | Home | Work | |
| Normal occupation prior to disablement. | | | | | | | | | | | |

Details of Injury

A. Give full description of injury from which you are suffering. State when, where and how it happened.(attach extra page if required)

| | | | | | | | | | | | | |
|----------------|--|----------------|--|----------|-----------------------|----|------|-----|----|--|--|--|
| Type of Injury | | | | | How did Injury occur? | | | | | | | |
| Date of Injury | | Time of Injury | | Training | Yes | No | Race | Yes | No | | | |

B. 1) Have you ever had this, or a similar condition in the past?

| | | | |
|--|-----|----|--|
| | Yes | No | |
|--|-----|----|--|

2) If yes, state nature of the condition and dates of treatment and names and addresses of treating doctors, hospitals or clinics. (attach extra page if insufficient space)

| | | | | | |
|---------------|--|------|--|------------|--|
| Condition (s) | | Date | | Treated By | |
|---------------|--|------|--|------------|--|

To be completed by the Club Secretary/Treasurer - Please ensure that all questions have been fully answered

I, of
(Secretary/Treasurer) (Name of Club)

hereby certify that sustained the injuries resulting in this
(Rider's Name)

claim on at am/pm, whilst racing/training
(Date) (Time)

..... at
(Place of Event)

Signed: Rider AVCC Licence No
(Secretary/Treasurer) (Date)

Club Mailing Address: Telephone:

To be completed by the State Veteran Cycling Council - Please ensure that all questions have been fully answered

I, of
(Association Official) (Name of Association)

hereby certify that is a registered member of the
(Rider's Name)
 abovementioned Association and I hereby sign this form in acknowledgement of the claim being made.

Signed:
(Association Official) (Date)

To be completed by rider

I hereby authorise any hospital, physician or other person who has attended to me, or any employer, to furnish QBE Insurance (Australia) Limited, or its representatives, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any fraudulent statements or conceal or suppress, or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sickness shall be forfeited.

| | | | |
|-----------|--|------|--|
| Signature | | Date | |
|-----------|--|------|--|

| | |
|---|--|
| When did you first consult a physician for this condition? | |
| When did you become totally disabled (unable to work)? | |
| When were you able to again perform part of your occupational duties? | |
| If still totally disabled, when do you expect your disability to terminate? | |
| When will you resume training? | |

Non Medicare Medical Expenses

You must pay the bill before submitting for Reimbursement by the Insurer

| | | |
|--|------------------------------|-----------------------------|
| Are you a member of a private health fund? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, which one? | | |
| Hospital Cover | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Extras covering dental/physio etc | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

NB Only forward accounts for services which are not subject to a Medicare rebate ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

| Date of Treatment | Name of Provider | Type of Service | Amount | Health Fund Rebate | Amount Claimed |
|-------------------|------------------|-----------------|--------|--------------------|----------------|
| a) | | | | | |
| b) | | | | | |
| c) | | | | | |
| d) | | | | | |

Give name and address and period of stay at hospital:

| Name | Addresses | From | To |
|------|-----------|------|----|
| | | | |

Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space)

| Name | Address | Telephone |
|------|---------|-----------|
| | | |

Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)

| Name | Address | Telephone |
|------|---------|-----------|
| | | |

Loss of Income Claims

| | | |
|---|------------------------------|-----------------------------|
| Are you entitled to receive compensation from any other source for this injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please provide details? | | |

If self-employed (Please attach proof of earnings over past 12 months eg. Tax Return)

| Name of Accountant | Address | Telephone |
|--------------------|---------|-----------|
| | | |

If employed as a wage earner (To be completed by your employer)

| | | |
|---|-----------------------|-----------------------------------|
| I HEREBY CERTIFY THAT: has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on: | | |
| He/She has been incapacitated since: and is expected to/did resume duties on: | | |
| His/Her gross basic salary (excluding bonuses, commission and overtime) at the date of injury was \$ per week | | |
| During the period of incapacity he/she received: | | |
| a) Normal pay: \$ | b) Sick Pay: \$ | c) Workers Compensation: \$ |
| From to | From to | From to |
| He/She has been employed since: | | Company Stamp: |
| His/Her sick leave entitlements at date of injury is: days | | |
| Name of Company: | | |
| Address: | | |
| Name of Supervisor or Paymaster (Please Print): | | |
| Signature..... Date: | | |
| Telephone No..... | | |

Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the company)

| | | | | | |
|---------------|--|---------|--|-----|-----|
| Patients Name | | Address | | Sex | M/F |
|---------------|--|---------|--|-----|-----|

| |
|--|
| <i>What is disabling patient? (Please give a complete diagnosis of this condition)</i> |
| |
| |
| |

History

| | | | | |
|---|-----|--------------------------|----|--------------------------|
| 1. When did patient first receive medical treatment? | | | | |
| 2. Was there a previous history of this or a similar condition? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| <i>If yes, please state condition and advise when previous treatment given.</i> | | | | |
| | | | | |
| 3. a) How long have you known the patient? | | | | |
| b) Are you the regular general practitioner? If no please advise who is? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| | | | | |

If Injury

| | |
|--|--|
| 1. When did patient suffer the injury? | |
| 2. What were the circumstances surrounding the injury? | |
| | |
| | |

If Disability

| | | | |
|--|--|----------------|--|
| 1. Patients occupation? | | | |
| 2. When was patient obliged to cease work? | | | |
| 3. If patient still disabled, when approximately will the patient be able to resume. | | | |
| a) some duties | | b) full duties | |
| 4. If patient has recovered, when was patient able to resume. | | | |
| a) some duties | | b) full duties | |

Treatment of Present Condition

| | | |
|---|---------|-------------------|
| 1. When were you consulted? | | |
| a) initially? | | b) most recently? |
| 2. How often has patient consulted you? | | |
| 3. Was patient confined to hospital? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes please advise Hospital Name | | |
| Address | | |
| Period of confinement From To | | |
| 4. Was confinement in a convalescent home necessary after hospitalisation? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes please give details. | | |
| 5. What are the current subjective symptoms. | | |
| 6. Please give results of any objective finding. | | |
| a) X-rays | | |
| b) Other test - Please advise test done and findings | | |
| 7. What surgical procedures have been performed? | | |
| 8. What surgical procedures have been contemplated? | | |
| 9. What other treatment has the patient undergone? | | |
| 10. What other treatment is required? | | |
| Are there any underlying conditions affecting recovery from the current condition? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes please advise nature of underlying conditions and how they affect disability and recovery. | | |
| Has patient any other physical or mental impairment? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes, please describe. | | |
| Please advise names and addresses of other treating physicians. | | |
| Name | Address | Telephone |
| | | |
| | | |
| | | |
| If you have terminated treatment, please advise date. | | |
| What is your current prognosis? | | |
| | | |
| Are there any further remarks which may assist in assessing this condition? | | |
| | | |
| Is there any permanent disability present? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes, please explain giving estimated percentage of loss of function. | | |
| | | |
| Name (please print name) | Address | Telephone |
| | | |
| Signature | Degree | Date |
| | | |