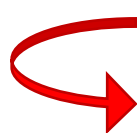


# HARNESS RACING AUSTRALIA



## PERSONAL INJURY CLAIM FORM



**Completed claim forms must be sent to;**

**V-Insurance Group**

Level 25, 123 Pitt Street

Sydney NSW 2000

Phone (02) 8559 8660 Fax (02) 8559 8661

Email [sports@vinsurancegroup.com](mailto:sports@vinsurancegroup.com)



**INSURANCE BROKER FOR HARNESS RACING AUSTRALIA;**

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

# HARNESS RACING AUSTRALIA SUMMARY OF INSURANCE COVER

## Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death capital benefit is \$250,000 for members aged 18-65, up to \$100,000 for members over 66 years of age (see policy for details) or \$250,000 for capital benefits other than death (\$50,000 for death) for persons 17 years and under.

## Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$10,000. Claimable expenses are private hospital bed and theatre fee, ambulance, dental, physiotherapy etc, net of any recoveries from private health insurance – subject to a nil excess. Cover is limited to expenses incurred within 12 months from the date of injury.

## Student Tutorial Costs

Reimburses up to 100% of costs incurred up to a maximum of \$500 per week for home tuition by a qualified tutor if the injury stops the Insured Person from going to their external tutor outside the home for up to 52 weeks with a 7 day excess period

## Domestic Help Benefit

Reimburses up to 100% of costs incurred up to a maximum of \$300 per week for a recognised and licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependent children such as child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 7 day excess period

## Loss of Income

Weekly Benefit 85% of earnings, if prevented from working in your occupation up to a maximum of \$1,000 per week. The benefit period is 104 weeks and the excess is 7 days. Non Harness Racing income is claimable for 52 weeks only.

## Funeral Benefit

We will pay up to an additional \$10,000 for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

## Important Notes

This insurance cover is underwritten by: Arch Insurance  
Level 4, 68 York Street, Sydney NSW 2000  
AFSL 426746 ABN 27 139 250 605

1. This summary of cover provides factual information about the Harness Racing Australia insurance program.
2. This summary of cover provides factual information about the Harness Racing Australia insurance program. The policy with full conditions is available at [www.vinsurancegroup.com/hra](http://www.vinsurancegroup.com/hra) or by contacting Harness Racing Australia.
3. This insurance program commenced on 1 September 2020 and expires on 1 September 2021.
4. V-Insurance facilitates this insurance program which provides benefits to those registered members of the Harness Racing 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.
5. Harness Racing 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 Harness Racing Australia insurance program can be obtained by visiting**

[www.vinsurancegroup.com/hra](http://www.vinsurancegroup.com/hra)

# HOW TO MAKE A CLAIM

Please find attached a claim form. Before lodging this form, please ensure all sections are fully completed. 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 6, please ensure you sign and date the Declaration.
3. For claims involving Loss of Income:
  - a) You must complete page 7 and have your employer/salary officer to complete page 7. If self-employed, you must have your accountant complete these details;
  - b) You must complete the Tax File Declaration form on page 8. 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 complete the section titled "Doctor's Statement" on pages 10 and 11.
4. For claims involving Non-Medicare medical expenses:

Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist etc).

  - a) Have your Attending Physician complete the "Attending Physician" statement on page 11.
5. Please attach copies of 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 to V-Insurance Group;

**V-Insurance Group**  
Level 25, 123 Pitt Street Sydney NSW 2000  
Phone +61 2 8599 8660  
Fax +61 2 8599 8661  
Email [sports@vinsurancegroup.com](mailto:sports@vinsurancegroup.com)
7. V-Insurance Group will manage your claim on your behalf and will be your point of contact. Corporate Services Network is the claims handling service that assesses claims and make payments where relevant, however V-Insurance Group will be your advocate and will be communicating with you.
8. Ongoing additional receipts/expenses that you incur or other correspondence relating to your injury must be sent to V-Insurance Group. Should you wish to make enquiries relating to the progress of your claim please contact us on (02) 8599 8660 or 1300 945 547.
9. Your reimbursement cheques/EFT transfers will be paid to you directly by Corporate Services Network. Any questions relating to these payments should be directed to V-Insurance Group.
10. 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 DETAILS

Claimant's Given Name:		Surname:	
Role at time of injury:		Member No (if applicable):	
Gender (please tick): <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:		Date of Birth: / /
Address		State	Postcode
			Email
Phone Number			
Work ( )	Home ( )	Mobile	

## DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I (insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Arch Insurance to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Pen Underwriting and their service providers in order to assess the claim. Arch Insurance complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_  
(or Legal Guardian if under 18 years of age)



**The following information is required for Harness Racing Australia research to assist with Risk Management. Answering these questions will not affect your claim.**

Surface at point of injury? (please tick)		Grass	<input type="checkbox"/>	
		Sand	<input type="checkbox"/>	
		Bare Dirt	<input type="checkbox"/>	
		Concrete/Bitumen	<input type="checkbox"/>	
		Gravel	<input type="checkbox"/>	
		Other (please advise details)	<input type="checkbox"/>	
		.....		
Weather conditions? (please tick)		Fine	<input type="checkbox"/>	
		Showers	<input type="checkbox"/>	
		Rain	<input type="checkbox"/>	
		Extreme heat	<input type="checkbox"/>	
		Extreme cold	<input type="checkbox"/>	
Type of involvement when the accident occurred?		Driving in race	<input type="checkbox"/>	
		Driving at training	<input type="checkbox"/>	
		Washing/Grooming/Stabling a horse	<input type="checkbox"/>	
		Track/Stable maintenance	<input type="checkbox"/>	
		Maintaining Equipment	<input type="checkbox"/>	
		Loading/Unloading a horse	<input type="checkbox"/>	
		Other (please advise details)	<input type="checkbox"/>	
		.....		
Sulky Type?	Not Applicable	<input type="checkbox"/>	Aerolite	<input type="checkbox"/>
	Easy Ride	<input type="checkbox"/>	Aussie Eclipse	<input type="checkbox"/>
	Sprintwell	<input type="checkbox"/>	Challenge	<input type="checkbox"/>
	Advantage	<input type="checkbox"/>	Regal	<input type="checkbox"/>
	Tsunami	<input type="checkbox"/>	Vitesse	<input type="checkbox"/>
	Evolution	<input type="checkbox"/>	Rio	<input type="checkbox"/>
	Razor	<input type="checkbox"/>	Other, please advise.....	<input type="checkbox"/>

## CLOTHING & EQUIPMENT

**(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR CLOTHING & EQUIPMENT DAMAGED WHILST BEING CARRIED OR WORN DURING A RACE)**

The Harness Racing Australia National Risk Protection Program's Personal Injury cover provides some reimbursement for costs associated with replacing damaged clothing or personal racing equipment sustained during a race.

Cover for replacement of damaged clothing or personal racing equipment is limited to **\$1,000 per claim**.

**Receipts** - If you have already replaced items and incurred costs, please submit your receipts to Corporate Services Network.

DESCRIPTION OF DAMAGED ITEM	COST (\$)
<b>TOTAL</b>	<b>\$</b>

## 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 \$..... <small>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.</small>	Date commenced employment with company: / /	
Income Definition: <input type="checkbox"/> Self Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the employee lodged or intending to lodge a Workers Compensation Claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### A. IF EMPLOYED

Salary officer's name:	Phone Number: ( )
Salary officer's signature:	Date: / /
Company Stamp:	ABN/ACN:

### B. IF SELF EMPLOYED

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







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 V-Insurance Group,  
 Level 25, 123 Pitt Street, Sydney NSW 2000 or via email  
 sports@vinsurancegroup.com

## 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 Medical Practitioner, Surgeon or Physiotherapist.
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?

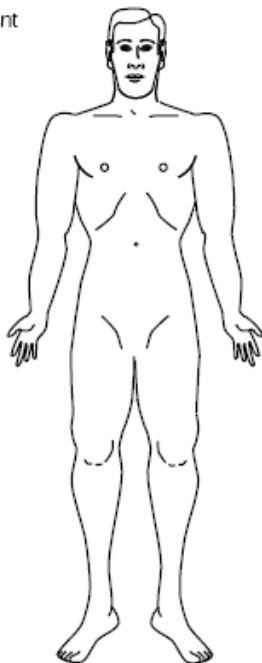
/ /

Are you the patient's regular general practitioner?     Yes     No

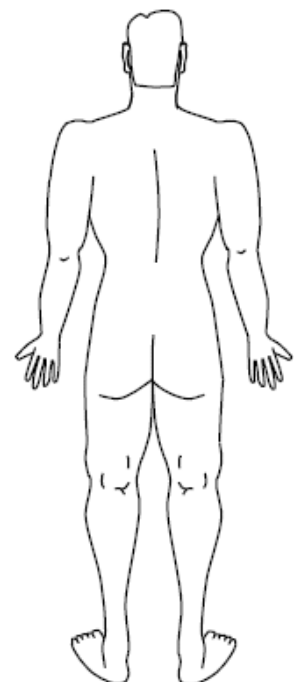
If not, please advise who is .....

What is the exact nature of the present injury?

Front



Back



Head





## 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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Nominated account name: \_\_\_\_\_

Bank, Credit Union, Building Society name: \_\_\_\_\_

Branch: \_\_\_\_\_

## DECLARATION

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