Pony Club Association of South Australia Inc.

PERSONAL ACCIDENT CLAIM FORM

Please read this page before completing the Claim Form

Dear Member

Thank you for your Claim Form request. This letter contains important information relevant to your Claim. Please read it carefully and make sure you understand its contents.

We require the Claim Form to be fully completed and returned within 120 days of your injury. DO NOT wait until treatment is complete before submitting the Claim Form.

1. The Medical Report of page 7 must be completed by the main Doctor, Chiropractor, Physiotherapist or Dentist who is providing treatment for your injury.

2. For Claims under the "LUMP SUM" Net Loss of Income Benefit your Employer must complete the Employer's Statement on page 6 and forward it directly to Gow-Gates. A Return to Work Statement from your Employer is also required before processing can be completed. If you are self employed, the financial statement on page 6 showing income details must be completed by your Accountant.

3. Please send all original receipts for Non Medical Expenses. If you are claiming from a Private Health Insurer, please send those statements along with your receipts.

4. Insurers will commence working on your claims immediately however, Claims cannot be settled (entitlements calculated) until all treatment to the injury has been completed, all accounts have been paid and refunds from your Private Health Insurer have been obtained. Claims for Loss of Wages will only be processed once insurers have been provided with a Return to Work date.

5. In most cases, there are varying Excesses on claims for Medical Expenses and an excess of varying periods on claims for loss of earnings. For precise details and information regarding Policy maximums and excesses, please contact your Club or Association.

6. Gow-Gates values your privacy and makes every endeavour to keep your personal details private and secure in accordance with the Privacy Act 1988. For further information on our privacy statement please visit our website at www.gowgates.com.au

If you have any queries, please call us immediately.

Telephone: 02 8267 9999
Email: equestrian@gowgates.com.au

Please send all correspondence to:

EQUESTRIAN DEPARTMENT
Gow-Gates Insurance Brokers Pty Ltd.
GPO Box 4731, Sydney, NSW 2001

Gow-Gates Insurance Brokers Pty Ltd, Level 8, 491 Kent Street, Sydney, NSW, 2000
P:(02) 8267 9999 F: (02) 8267 9998 E: equestrian@gowgates.com.au
ABN 12 000 837 785 | AFSL 245432

Before you commence filling in this form, please make sure you have read and fully understood the dialogue on the front of the claim form as it contains important information relating to your claim. If you have any questions at all about its content or meaning, please contact the Gow-Gates office.

PART 1 – CONTACT / CLAIMANT DETAILS

Name of Claimant	
Date of Birth: / /	Sex: Male / Female
Occupation:	
Home Address:	
Correspondence Address:	
Telephone:	Mobile:
Email:	Alternative Phone:
Australia Permanent Residence: Yes / No	Other (please specify):
Sport:	
Club:	

1. a)	Please give a full description of the circumstance of the accident which led to the injury.

1. b)	When did the injury occur?	Date:	Time:

1. c)	Please provide the address of where the injury occurred.

2. a)	What injuries did you receive?

2. b)	When did you first consult a practitioner for this injury?	Date:

2. c)	Is treatment complete for this injury? Yes / No	If NO please notify us in writing as soon as it is.

3.	Were you admitted to Hospital? Yes / No If Yes Name and Address of Hospital

3.a)	Were you an: In Patient Yes / No Out Patient Yes / No What was the Name of Attending Doctor:

4)	Are you now, or have ever been, subject to or affected by other Injury or Disease, Deformity, Defect of Senses, Infirmity or Weakness? Yes / No If Yes, please provide details

5)	Have you ever lodged a personal accident claim before? Yes / No If Yes, please provide details

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6.a) Are you a member of a Private Health Insurance Fund? Yes / No
If Yes, please provide details

6.b) If Yes, are you entitled to claim for any of the following benefits?

Private Hospital	☐	Physiotherapy	☐	Dental	☐
Chiropractic	☐	Ambulance	☐	Massage	☐

Other ancillary services. Please give details

7) If you intend making a loss of wages claim, are you making or entitled to make a claim in respect of this injury for any of the following?

Sick Leave:	Yes / No	Workers Compensation:	Yes / No
Motor Government Benefits:	Yes / No	Superannuation Life Insurance	Yes / No
Income Protection (for example: Personal or via Superannuation Fun			Yes / No
Centrelink Sickness	Yes / No		

If Yes, please give details

PLEASE NOTE

Original receipts and all statements of any benefits received from any source must be sent to Gow-Gates as soon as possible. Failure to do so will result in Settlement Delays. Please also remember to inform us in writing when your treatment is complete. This will also reduce delays in settlement of your claim.

PART 2 – SETTLEMENT DETAILS

NOTE – For your convenience please complete the direct bank deposit information below. This will provide you with immediate access to the funds as there are no postal or cheque clearance delays.

_____ Mail Cheque _____ Direct Bank Deposit (if bank deposit, please give details below)

BANK NAME											
BENEFICIARY NAME											
BSB NUMBER							Maximum 6 digits				
ACCOUNT NUMBER										Maximum 9 digits	

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PART 3 – DECLARATION AND AUTHORISATION BY INJURED PERSON

NAME: _____

Surname Given Names

I hereby authorise any hospital, physical, medical practitioner, medical specialist or any other person who has attended me and/or employer of mine, past or present, to furnish Gow-Gates and/or its representatives with any and all information with respect to any sickness or injury, medical history, consultants, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers including verification or my earnings.

I acknowledge that any personal information that I have or will provide to Gow-Gates is necessary for and will be used in processing, assessing, investigation or review of this claim. I hereby authorise Gow-Gates and/or its representatives and consent to Gow-Gates and/or its representatives and its authorised agent to disclose any personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, appointed/authorised broker, account broker, and/or broker of the entire/body corporate/organisation insured (Insured), State or Federal Authority, lawyer, another insurer or reinsurer (local or overseas), reinsurance broker, witness or another party to the claim. I will be provided with the opportunity to access my personal information (some restrictions and costs may apply). In respect of any complaint I may have regarding my personal information, I can contact the Gow-Gates office.

I agree that a photocopy / scanned copy 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.

Signature Date / /

WARNING: Persons found to have lodged a fraudulent claim are liable for prosecution.

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Complete this section only if you wish to claims for loss of earnings

PART 4 – DETAILS OF EMPLOYMENT

PLEASE NOTE
A claim cannot be made unless the claimant was gainfully employed at the date of injury
The Claimant must be continuously and totally disabled for more than the excess period noted in the Policy

Current Employer's Name:

Current Employer's Address:

Contact Name:

Contact Telephone Number:

1. At the time of the accident were you (please select as appropriate)

   _____ Full Time Employee

   _____ Part Time Employee Working _____ hours per week

   _____ Self Employed on a full time basis

   Period of Employment

2. What is you Occupation / Position?

3. What are your Gross Earnings per annum from this Employer?

4. When did you cease work as a result of your injury? / /

5. Have you returned to work? Yes / No If Yes, when? / /

6. Please give details of your entitlements (if any) to each of the following benefits:

		Number of Weeks	Weekly Amount	Total Entitlement
a)	Sick pay from your employer			
b)	Other insurance benefits including Personal Accident Policies			
c)	Centrelink			
d)	Other salary, wages, income or pay of any nature whatsoever being:			
	If other sources, please describe briefly			
			Total Entitlements =	
7.	What was your income from all sources in the twelve months period prior to your accident?		Total Annual Income From all Sources =	

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8. Have you worked at more than one place of employment within the twelve month period prior to your accident? Yes / No

If Yes, please provide details below showing full names and addresses – no abbreviations.

a) Former Employer – Contact Name

Telephone Number

Address

Occupation / Position

Period of Employment / / to / /

Please list any additional former employers on a separate list. Leave blank if not applicable)

EMPLOYER'S STATEMENT – to be completed by Claimant's current Employer

I _____ Manager / Accountant / Director / Partner (please select)
of _____ (Name of Company)
at _____(Address of Company)
confirm that _____ has been employed continuously by this firm in the position of _____ since _____/_____/_____
His/Her gross earning since the above date of employment (if less than 12 months ago) or for the past 12 months up to the date of his/her injury as described on this claim form amounted to $_____
At the _____/_____/_____ (date of injury), the claimant was entitled to _____ sick days pay.
I confirm that the claimant was not entitled to receive, nor did receive any form of remuneration whatsoever from this firm, his employer, in respect of his/her period of disablement commencing at the above-mentioned date of injury; except as follows:

_____

_____

Signature_____ Date_____/_____/_____

ACCOUNTANT'S STATEMENT – to be completed by Claimant's Accountant – For Self Employed Person's Only

I _____ Manager / Accountant / Director / Partner (please select)
of _____ (Name of Company)
at _____ (Address of Company)
confirm that our firm acts as Accountants for _____ (Name of Claimant) at _____ (Address of Claimant)
and that His/Her gross earnings (before tax but after expenses) for the 12 months period ending _____ / _____ / _____ (date of injury) amounted to $_____
Income Protection Yes / No If Yes, name of company_____
Signature_____ Date_____/_____/_____

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MEDICAL REPORT

PLEASE NOTE – These questions are to be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor.

IMPORTANT: If you are claiming for Loss of Income this section MUST be completed by your DOCTOR. The insured is responsible for the completion of this form and any charges incurred for its completion.

PATIENT'S DETAILS

Name:

Address:

Telephone:

Email:

What is disabling the patient? *(Please give a complete diagnosis of this condition)*

History

1. When did the patient first receive medical treatment for this injury? / /

2. a) Was there a previous history of this or similar condition? Yes / No

   b) If Yes, please state the condition and advise when previous treatment was given.

3. a) How long have you know the patient?

   b) Are you the claimant's regular practitioner Yes / No

   c) If No, please advise who is

Injury

1. When did the patient suffer the injury? / /

2. What were the circumstances surrounding the injury?

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Degree of Disability

1. Patient's Occupation:

2. When was the patient obliged to cease work? / /

3. If patient is still disabled, when approximately will the patient resume:

   a) some duties / / b) full duties / /

4. If patient has recovered, when was the 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 the patient consulted you?

3. Was patient confined to hospital? Yes / No

4. If Yes, please advise a) Name of Hospital
   b) Period of Confinement from / / to / /

5. Was confinement in a convalescent home necessary after hospitalisation? Yes / No

6. What are the current subjective symptoms?

7. Please give results of any objective findings:

   a) X-Ray's, MRI's
   b) Other tests – please advise tests done and findings 1.
   2.

8. What surgical procedures have been performed?

9. What surgical procedures have been contemplated?

10. Are there any underlying conditions affecting recovery from the current condition? Yes / No
    If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery:

11. Has patient any other physical or mental impairment? Yes / No
    If Yes, please describe

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12. Please advise names and addressed of other treating physicians

Name:

Address:

13. If you have terminated treatment, please advise date: / /

14. What is the current prognosis?

15. Are there any further remarks which may assist in assessing this condition?

16. Is there any permanent disability at present? Yes / No
If Yes, please explain giving an estimated percentage loss of function:

PHYSICIAN'S DETAILS

Full Name _____

Qualifications _____

Street Address _____

Telephone _____

Email _____

Website _____

Signature _____ Date _____ / _____ /_____

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