

Injured Player's Authorisation and Declaration

I hereby authorise any hospital, physician or other person who has attended me or any employer and the Department of Social Security, to furnish QBE or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatment, copies of all hospital 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.

The information and answers given above are true and complete in every detail.

I understand the claim may be refused or reduced if information is withheld.

I authorise that QBE give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

I have read and understand the information sheet that tells me what I am covered for by this Policy.

Signature of Injured Player _____

Date / /

DELAYS IN SEEKING MEDICAL ADVICE AND THE IMMEDIATE COMMENCEMENT OF RECOMMENDED TREATMENT COULD PREJUDICE YOUR ENTITLEMENT UNDER THE POLICY

Income and Employment Details - For Employees

Employer								
Address				State	Postcode			
Date commenced with employer	/	/	Date ceased work due to injury	/	/			
Expected resumption date	/	/						
Gross weekly income prior to injury	\$		Gross annual income	\$				
Details of payments during time off work (ie Holiday/Sick leave)								
Paid from	/	/	to	/	/			
Salary Officer's Name				Telephone No.	()			
Salary Officer's Signature	<input checked="" type="checkbox"/>				Date	/	/	/

Income and Employment Details - for Self-Employed persons

You must provide all the details above on a Statutory Declaration and have it signed and witnessed by a Justice of the Peace. You must also advise on the Statutory Declaration whether or not you have any other Personal Accident or Income Protection policy that you can claim on for this injury. If you do, you should advise the name of the insurer and contact phone number, policy number, sum insured per week or per month, and the waiting period or excess. You must also send a copy of your last Taxation Assessment Notice and Profit/Loss Statement.

Club Official Declaration

This is a legal document and false declaration can result in legal implications for both the individual and the Club.

I, _____ of _____								
Club official of (title)	Club							
Northern NSW Soccer <input type="checkbox"/>	Soccer NSW <input type="checkbox"/>	Certify that						
		Player						
Sustained injuries resulting in this claim on	/	/	at		am/pm			
whilst training/playing at								
Club mailing address				Postcode				
Is the player a registered player?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Registration No.					
Did the player appear on official team playing sheet?	No <input type="checkbox"/>	Yes <input type="checkbox"/>						
Rate: Student <input type="checkbox"/>	Non student <input type="checkbox"/>							
Club Official's Signature	<input checked="" type="checkbox"/>				Date	/	/	/
Telephone Number	Home	()	Business	()				
Association Representative's Signature	<input checked="" type="checkbox"/>				Date	/	/	/
Association Representative's Name and Title								

Physician's Statement

Must be completed by a dentist, doctor or surgeon not by a physiotherapist or chiropractor. Any expense for the completion of this statement can only be met by the patient and not by the insurer.

Patient's Name
Surname Given Name(s)

CONDITION – give a complete diagnosis of this condition

HISTORY

When did the patient first suffer the injury? Date / / Time am/pm

What did the patient tell you were the circumstances surrounding the injury?

When did the patient first receive medical treatment? Date / /

When were you first consulted? Date / / Time am/pm

Was there a previous history of this or a similar condition? No Yes – When was treatment given?

Were there any structural deficiencies or weaknesses to this region prior to this injury that directly contributed to this injury? No Yes

Is there any underlying condition affecting recovery from the current condition? No Yes

If "Yes", advise nature of underlying condition and how it affects disability and recovery:

DEGREE OF DISABILITY

When was the patient obliged to cease work? Date / / Time am/pm

If the patient is still disabled, when will the patient be able to resume:

• one or more of the material tasks of their occupation? Date / /

• all of the tasks of their occupation? Date / /

If the patient has recovered, when was the patient able to resume:

• one or more of the material-tasks of their occupation? Date / /

• all of the tasks of their occupation? Date / /

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

Physician's Statement (continued)**REFERRAL (Must be completed for supporting services)**Physiotherapy Chiropractic Osteopathic Massage Services Other Date Referred / / Number of treatments Number of weeks Review date for further referral for treatment / / **HOSPITAL DETAILS**Was the patient confined to hospital? No Yes - Give details

Name of Hospital	Address	Period of Confinment	
		From	To
		/ /	/ /
		/ /	/ /
		/ /	/ /

OTHER DETAILS

What are the current symptoms?

Give results of any objective findings:

X-rays Other Tests - specify

What surgical procedures have been performed or are being contemplated?

Advise names and addresses of other treating physicians

Name	Address

Have you terminated treatment? No Yes - On / /

What is the current prognosis?

Are there any further remarks which may assist us in assessing this condition? No Yes - Give details

Doctor's Name Qualifications Address State Postcode Telephone () Signature Date / /