Australian Sailing

Group Personal Accident Insurance

Summary of Insurance Cover & Claim Form

Network Insurance House | **1300 655 037**
sailing@nih.com.au | nih.com.au
Level 31, 300 La Trobe Street Melbourne VIC 3000
PO Box 3190 Tuggerah NSW 2259

SUMMARY OF COVER

The following is intended as a summary only.
Please refer to the Product Disclosure Statement (PDS), Policy Schedule and Policy Endorsements, available from our website for full terms, conditions and exclusions that apply.

Who is insured?

Category 1: All current financial members of Australian Sailing Affiliated Clubs (including Sail Pass participants) that are registered in the Australian Sailing database and includes all Instructors, Officials and Coaches.

Category 2: Voluntary workers, Directors and Committee members of:

- Australian Sailing Limited;
- All State and Territory Member Yachting Associations (MYA),
- All Australian Sailing Affiliated Clubs.

Category 3: Accredited Discover Sailing Course Participants and Discover Sailing Day Participants that are registered in the Australian Sailing database.

When are you Insured?

The Australian Sailing Group Personal Accident Insurance policy provides cover for an Insured Person while participating in Australian Sailing Affiliated Yacht Club sailing and training activities.

Please refer to the Policy Schedule for full scope of cover details

Non-Medicare Medical Expense

The Australian Sailing Group Personal Accident Insurance policy reimburses up to 100% of Non-Medicare medical expenses not recoverable from private health insurance up to a maximum of $5,850 subject to a $50 excess. Medical Expenses covered by Medicare are not covered by policy.

The following table is intended to help understand what expenses that are covered and not covered by the Non Medicare Medical Expenses benefit under the policy:

Covered	Not Covered
Physio / Chiropractor Ambulance Theatre fee Private hospital bed	Surgeons, Anaesthetists Doctors, X-rays Other partly covered by Medicare (Medicare Gap)

Other Benefits

Loss of Income
Pre-Injury Salary, if prevented from working

Death & Permanent Disablement
A lump sum benefit is payable in the event of death or a Permanent Disability.

Funeral Benefit
Will pay for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

Broken Bones
Up to $5,000 any one accident.

Student Tutorial Costs
Reimburses home tuition by a qualified tutor if the Injury stops the Insured Person from going to their external tutor outside the home .

Domestic Help Benefit
Reimburses licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependent children

This insurance cover is underwritten by Berkshire Hathaway Specialty Insurance
ABN 84 600 643 034 | AFSL 466713

CLAIM FORM

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 or rejection of your claim.

How to Complete this Claim Form

One claim form (per injury) is required.
A claim form should be completed and submitted as soon as reasonably possible You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

SECTION 1 Is to be completed in full by the claimant for all claims

SECTION 2 Is to be completed in full by the claimant for all claims

SECTION 3 Declaration by Association/Club
Needs to be completed by the Club where you are a member for all claims.

Note: This section should be submitted to your club to complete once you have fully completed all other sections of the claim form. This section is intended to confirm you are a member of and Australian Sailing Affiliated Club and that your injury occurred during an Australian Sailing affiliated yacht club sanctioned activity.

SECTION 4 Only complete this section if you are claiming Non-Medicare Medical Expenses (including Physio/ Dental).

Please attach all itemised receipts (be sure to copy them before you claim with your health fund as they will retain the original). Hospital claims must be accompanied by an itemised Invoice, not just the estimate. If treatment or a cost incurred is covered by your Private Health Fund, please send their rebate advice with a copy of the relevant account.

SECTION 5 Only complete this section if you are claiming Loss of Weekly Income (including Student Tutorial/ Home Help).

Please attach a minimum of the 3 months of pay slips for prior to the date of injury.
If claiming Student Tutorial or Home help, please attach receipts for expenses incurred

SECTION 6 Must be completed and signed by you to enable claim settlement

SECTION 7 Must be signed by you for the claim to be considered

SECTION 8 Must be completed and signed by your attending physician for all claims

SECTION 9 Must be completed and signed by your employer if you are claiming Loss of Weekly Income

Where to Return your Claim Form

Once you have completed your claim form, please forward to:

Network Insurance House
PO Box 3190 Tuggerah NSW 2259
sailing@nih.com.au
Tel: 1300 655 037

What happens Next?

We will review your claim and submit it to the insurers Claims team. You will be provided with confirmation of your claim lodgement, together with details on how to track you're the progress of your claim.

Queries & Assistance

We can be reached on the above contact details should you wish to make enquiries relating to the completion of this claim form or the progress of your submitted claim.

SECTION 1: Claimant Details
Required for ALL claims

Claimants Name		Date of Birth	
Club Name		Member No	
Occupation		Gender	
Address		Postcode	
Email		Phone	
Please tick the category applicable: ☐ Participating Member ☐ Official ☐ Sailing Course Participant ☐ Volunteer ☐ Other (detail below)			
Event or other activity			
Name of Team / Age Group / Grade			
Name of Boat			

SECTION 2: Accident Details (to be completed by the claimant)
Required for ALL claims

Describe how the accident happened				
Describe your injury				
When did your accident Occur? Date		Time		am/pm
What was your activity at the time of the Incident? (Please Tick) ☐ Organised Training ☐ Officially Organised Competition ☐ Social or Private Competition ☐ Sanctioned fundraising / social event ☐ Travelling to and/or from activity				
Address of where injury occurred		Postcode		
State the name of any witness of the injury				
Witness Address		Postcode		
Person to whom accident was reported				
Date and time accident was reported		Time		am/pm
Brief summary of treatment/action taken at the time of the accident/incident				
Was hospitalisation required? *If yes, please complete below* ☐ Yes ☐ No				
Name of hospital				
If admitted, how long were you there?				
Name of treating physician				

Advise below when you did (or expect to):

Cease work/normal activities		Resume work/normal activities	
Cease training		Resume training	
Cease participating		Resume participating	
Have you ever had this injury or similar injuries in the past? *If yes, please complete below* ☐ Yes ☐ No			
When?			
Details			

SECTION 3: Declaration by Association

Required for ALL claims

The following section must be completed by a club official representing the Australian Sailing Affiliated Yacht Club/Class Association who was hosting the event you were participating in at the time of injury.

Name of Association/Club	

Details of Official making this Statement

Name		Position	
Address		Postcode	
Email		Phone	

Do you have any comments in relation to this claim? (If yes, please specify)	☐ Yes ☐ No

☐ I, the above mentioned Australian Sailing or Club Official, confirm that the claimant was a registered and financial member of this club at the time of the accident, that the information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

☐ I, confirm that the claimed accident occurred at an Australian Sailing Affiliated club premises, including an organised event; OR at an event that was organised by or sanctioned by World Sailing or one of World Sailing's Member National Authorities, including but not limited to Australian Sailing.

Signature of Association/Club Official		Date	

SECTION 4: Non-Medicare Medical Expenses

Only complete this section if claiming for these expenses

Do not attach accounts paid or part paid by Medicare. The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap).

Are you a member of an Ambulance Service?	☐ Yes	☐ No
Are you a member of a Private Health Fund? *If yes, please provide details*	☐ Yes	☐ No
Do you have hospital cover?	☐ Yes	☐ No
Are you covered for Extras including Physio etc?	☐ Yes	☐ No

Itemised Account

Itemised accounts and receipts must be submitted together with details of Benefits from any Private Health Insurance (attach additional sheet if more space is required)

Provider	**Service** *(eg dental)*	**Date**	**Charge**	**Private Fund Recovery**	**Amount Claimable**
			$	$	$
			$	$	$
			$	$	$
			$	$	$

SECTION 5: Loss of Income

Only complete this section if claiming for loss of income

Section 9 must be completed by your employer prior to submitting your claim

Can compensation be claimed under worker's compensation or any other insurance including Loss of Income?	☐ Yes	☐ No
Have you ever made any previous claims in respect to personal accident insurance or any other similar insurance	☐ Yes	☐ No
Have you engaged in any other income earning employment since you have been injured	☐ Yes	☐ No

SECTION 6: Method of Payment

To be completed for ALL claims

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to the below nominated bank account

Bank Account Details

Bank			
Account Name(s)			
BSB Number		Account Number	

SECTION 7: Declaration & Authorisation by Claimant
Required for ALL claims

PRIVACY NOTICE
We, along with all companies in the Berkshire Hathaway group of insurance companies, are committed to safeguarding your privacy and the confidentiality of your personal information. We, and entities acting on our behalf, only collect personal information from or about you for the purpose of assessing your application for insurance and administering your insurance policy, including managing and administering any claim made by you. Without your personal information, we may not be able to issue insurance cover, administer your insurance or process your claim. We will only use your personal information in accordance with the Privacy Act 1988 (Cth) and for the purposes outlined above.

We may disclose your personal information to other companies in the Berkshire Hathaway group and other third-party service providers for the purposes outlined above or where disclosure is permitted by law. These entities may be located in Australia or overseas, including in New Zealand, India, Malaysia, Singapore, Hong Kong, France, Germany, the United Kingdom, Canada and the United States of America. Where such disclosure is made, we make all reasonable efforts to ensure that the arrangements we have in place with overseas parties impose appropriate privacy and confidentiality obligations on those parties to ensure that imparted personal information is kept secure and that such information is only used for the purposes noted above.

If you wish to obtain details of the personal information we hold about you (including contacting us to correct or update the personal information we hold about you), or if you have a complaint about a breach of your privacy, please refer to our privacy policy available at https://www.bhspecialty.com/privacy-policy-australia/ , or contact us by email to australasia.privacy.compliance@bhspecialty.com

We reserve the right to refuse access under the grounds permitted by the *Privacy Act 1988* (Cth) and, if you are seeking information on another person's behalf, we will require written authorisation from that individual.

AUTHORITY TO GIVE INFORMATION
I/we hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

DECLARATION
I, the Claimant, hereby declare that the foregoing statements are true and correct:

Name: _____ **Position:** _____

Signature: _____ **Date:** _____

SECTION 8: Attending Physician Statement
Required for ALL CLAIMS

The following section must be completed by your attending physician
This form can only be completed by the treating Medical Practitioner, Surgeon or Physiotherapist. **Dashes or blank spaces are not acceptable**. The patient is responsible for any fee for this statement.

Patients Full Name		Date of Birth	
Are you the patient's General Practitioner?			☐ Yes ☐ No
If not, name of their usual doctor			
How long have you known the patient?			
What date were you first consulted by the patient in connection with the present injury?			
On what date did the patient first seek medical treatment for the present injury?			
Name of first treatment provider for present injury			
What is the exact nature of the present injury? *(Please detail symptoms, diagnosis & how injury was sustained)*			
Has the patient ever suffered this or a similar condition before?			☐ Yes ☐ No
If yes, please state condition and advise when previous treatment was given			
Have you referred the patient to any other services or treatment?			☐ Yes ☐ No
Please specify the type (e.g. physiotherapy/chiropractic) and approximate number of treatments required			
Type		Number of treatments	
Type		Number of treatments	
Have any Surgical Procedures been performed? *If yes, please specify*			☐ Yes ☐ No
Have any Surgical Procedures been contemplated?			☐ Yes ☐ No
Any further remarks which may assist in assessing this condition			
Is there a disability at present? *If yes, please explain giving estimated percentage loss of function*			☐ Yes ☐ No
Was the patient obliged to cease work?			☐ Yes ☐ No
When do you expect the claimant to resume work?		Some Duties	
		Full Duties	
Does the patient have any congenital defects or chronic diseases? *If yes, please give dates, name of treating doctor and describe*			☐ Yes ☐ No
If the patient has been hospitalised, please give name of hospital and dates hospitalised			
Name of Hospital			
Date Admitted		Date Released	

Section 8 continued on next page

SECTION 8: Attending Physician Statement (Cont.)

Certification by Attending Physician

Name		Qualifications	
Address		Postcode	
Email		Phone	
Signature		Date	

SECTION 9: Loss of Income Declaration

To be completed for ALL Loss of Income claims

The following section must be completed by your employer/salary officer. If self-employed, please have your accountant complete these details.

Name of Employer					
Address			Postcode		
Phone			Fax		
Date ceased work due to injury		Date expected to resume normal duties			
Employee weekly salary as at date of injury: Average Gross Base Salary		$		Per Week	
Base salary, exclusive of overtime, allowances, bonuses & commissions 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.					
Date commenced employment with company					
Income definition (Please Tick) ☐ Self Employed ☐ Full Time ☐ Part Time ☐ Casual					
During the period of incapacity the employee received					
$	**Normal pay**	From		To	
$	**Sick Pay**	From		To	
$	**Workers Compensation**	From		To	
$	**Other**	From		To	
If other, please specify					
Has the employee returned to work? ☐ Yes ☐ No					
Has the employee lodged or intending to lodge a Workers Compensation claim? ☐ Yes ☐ No					

A - IF EMPLOYED - To be completed by the Salary Officer

Name				Company Stamp
Phone				
Email				
ABN/ACN				
Signature		Date		

B - IF SELF-EMPLOYED

Entity				Company Stamp
ABN/ACN				
Signature		Date		