GROUP PERSONAL ACCIDENT

Instructions

1. Please fully complete/attach the following:
   - ☐ All sections in the claim form
   - ☐ Signed and dated the declaration form
   - ☐ Any written medical reports by medical practitioner from within the 12 months of the disability
   - ☐ Proof of identification (certified copy of driver's licence or passport)
   - ☐ Tax file number declaration (TFN)

2. When the claim form has been completed in full, signed and dated, please send it with attachments as a PDF file to:

   Speedway Australia
   PO Box 269
   STEPNEY SA 5069
   admin@speedwayaustralia.net.au
   www.speedwayaustralia.net.au

   If you have any enquires, or need assistance with understanding or completing this form, you may contact Speedway Australia (Speedway). Please ensure that you keep copies of all documentation sent to Speedway. All correctly completed documentation received by Speedway will be forwarded to the insurers who will make direct contact with you.

Important Notice

Please do not:

- forward claim forms directly to the Insurer. Forward all claims with a copy of your licence to the Speedway Australia office.
- forward unpaid medical or ambulance accounts with claim forms. All accounts should be paid and receipts forwarded with the claim form for reimbursement.
- forward copies of accounts or receipts. All accounts and receipts should be originals.
- forward Medicare receipts.

3. Payment details

   Please choose your preferred payment method below:

Australian Bank Account

Name of bank/credit union	
Account name	
Account number	☐☐☐☐☐☐☐☐☐
BSB	☐☐☐ ☐☐☐
Australian dollar cheque (please provide address on separate sheet if required)	Yes ☐ No ☐

CLAIMANT CERTIFICATION

Name of club or association of which you are a member

Speedway venue at which accident occurred

Race vehicle category competing in at time of accident

YOUR DETAILS

Name

Address line 1

Address line 2

Suburb | State | Postcode

Email | Date of birth

Do you consent to receive important information about your claim form via email? Yes ☐ No ☐

Telephone Home | Work | Mobile

Occupation

Usual duties

In what capacity were you participating in the meet?

Driver ☐ Official ☐ Mechanic ☐ Other (Please specify)

DECLARATION OF EARNINGS

Important information

You will be required to supply proof of your income by submitting copies of your payroll history or your personal and business income tax returns for the full financial year immediately preceding the injury for which you are now claiming.

If you are self-employed

Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses in incurring that income. Please complete **Section 1**.

If you are not self-employed

Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions and any other items already agreed by us. Please complete **Section 2**.

SECTION 1: SELF-EMPLOYED PERSONS (TO BE COMPLETED BY YOUR ACCOUNTANT)

Business/trading name

Address line 1

Address line 2

Suburb | State | Postcode

Current weekly earnings (please refer to Important Information on previous page) $

Accountant's name

Accountant's signature

SECTION 2: EMPLOYED PERSONS (TO BE COMPLETED BY YOUR EMPLOYER)

Business/trading name

Address line 1

Address line 2

Suburb | State | Postcode

Current weekly earnings (please refer to Important Information on previous page) $

DETAILS OF INJURY

Give full description of the injury from which you are suffering (attach an extra page if necessary)

Type of injury

How did the injury occur?

Where did the injury occur?

Date of injury | Time | Date of disablement

Name of person/s who witnessed the accident and telephone number/s

Name | Telephone

Name | Telephone

Name | Telephone

Was the activity in which you were engaged, at the time you injured yourself, an activity which was sanctioned and scheduled by the insured organisation?	Yes ☐	No ☐
Have you had any other injuries to similar parts of the body? (If yes, please attach extra page with details)	Yes ☐	No ☐
Are you aware of any previous medical history, health issues or injuries that may affect your recovery from the injury? (If yes, please attach page with details)	Yes ☐	No ☐
Are you claiming from any other insurance or compensation claim in respect of disability?	Yes ☐	No ☐

If yes, please provide details below:

Type of insurance

Company

PRIVACY NOTICE

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at privacy.officer.ap@libertyglobalgroup.com or call +61 2 8298 5800 and/or CSN's Privacy Officer at privacy@csnet.com.au or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website (csnet.com.au) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty using and disclosing my personal information pursuant to their Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty in their absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN or Liberty in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN or Liberty to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of claimant Date

Name of claimant

Signature of Witness (any adult person) Date

Name of witness

Note: This claim form can be printed for signing and sent by email as one PDF document, along with any accounts or medical reports, if preferred.

ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT: Your medical practitioner must complete the attending physician's statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement. Any charge for this statement must be borne by the patient. Please complete all sections.

Patient's name

Address line 1

Address line 2

Suburb | State | Postcode

History

When did the patient first receive medical treatment?

Was there a previous history of this or a similar condition? Yes ☐ No ☐

If yes, please state the condition and advise when previous treatment was given:

How long have you known the patient?

Are you the regular practitioner? Yes ☐ No ☐

If no, please advise who is:

When did the patient first suffer the injury? Date | Time

What were the circumstances surrounding the injury?

Degree of disability

When was the patient obliged to cease work? Date | Time

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

One or more of the material tasks of occupation? | All tasks of their occupation

If the patient has recovered, when will they be able to resume:

One or more of the material tasks of occupation? | All tasks of their occupation

Treatment of present condition

1. When were you consulted?

a. Initially b. Most recently

2. How often has the patent consulted with you?

3. Was the patent confined to hospital? Yes ☐ No ☐

If yes, please advise:

Hospital name

Address line 1

Address line 2

Suburb State Postcode

Period of confinement From To

4. Was confinement in a convalescent home necessary after hospitalisation? Yes ☐ No ☐

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 tests – 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? (Please provide treatment/management plan)

11. Are there any underlying conditions affecting recovery from the current disability? Yes ☐ No ☐

If yes, please advise the nature of their underlying conditions and how they affect their disability and recovery:

Do you believe occupational rehabilitation would benefit this patient? Yes ☐ No ☐

If you terminated their treatment, please advise the 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 ☐ No ☐

If yes, please explain, giving the estimate percentage of loss of function:

Name (please print)

Address line 1

Address line 2

Suburb	State:	Postcode:
Telephone	Qualifications	

Signature Date

SPEEDWAY AUSTRALIA CERTIFICATION

This part of the claim form needs to be completed by a Speedway Australia Administration Officer

Name of injured person

Event participating in

Name of club

1. On what date did the licence holder of the insured organisation sustain the injury?		
2. Was the activity in which the licence holder of the organisation was participating in at the time of injury an officially authorised and sanctioned activity of the insured organisation?	Yes ☐	No ☐
3. What is the injured person's licence holder number?		
4. Was the injured person an annual licence holder of the insured organisation at the date of injury? (If not, proceed to question 5)	Yes ☐	No ☐
5. Did the injured person possess a day licence of the insured organisation at the date of injury? (If not, proceed to question 6)	Yes ☐	No ☐
6. Did the injured person possess a pit pass of the insured organisation at the date of injury?	Yes ☐	No ☐

SPEEDWAY AUSTRALIA DECLARATION

I am an authorised officer of Speedway. I declare that the information provided in this certification is true, correct and completed to the best of my ability.

Name | Title of office bearer

Signature | Date