

**QBE INSURANCE (AUSTRALIA) LIMITED**ABN 78 003 191 035  
Box 82 GPO Sydney NSW 2000  
Telephone 02 9375 4444 Facsimile 02 9375 4885**Please return this form to – GAB Robins Australia PO Box 7732 BAULKHAM HILLS BC NSW 2153  
Telephone: 02 8858 6000 – Facsimile:02 9899 6999****NSW Junior Rugby League – Sports Injury Report Form**

Players Name:							
Address:						Post Code:	
Telephone:	Home -		Work -		Mobile -		
Date of Birth:			Height:		Weight:		Sex: M / F
Normal occupation prior to disablement:							
Name of Club, Grade & Team:			Registration Number:	Position Played:			
<b>DETAILS OF INJURY:</b>							
<b>A. Give full description of injury from which you are suffering. State when, where and how it happened (attach extra page if required).</b>							
Type of Injury:				How did injury occur?			
Place where you were injured:							
Date of Injury:		Time:		Training: Yes <input type="checkbox"/> No <input type="checkbox"/>	Playing: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>B. 1) Have you ever had this, or a similar condition in the past?</b>				Yes <input type="checkbox"/>	No <input type="checkbox"/>		
2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).							
Condition (s):			Date:		Treated By:		

**To be completed by the Club Secretary/Treasurer.  
Please ensure that all questions have been fully answered.**

Name of Player	was injured as stated.						
Grade with the Club							
Name of Club							
Secretary/Treasurer's Name			Telephone				
Address			Post Code				

**I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.**

Signature		Date		Witness		Date	
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<b>District Administrator's Acknowledgment:</b>	(Signature and Date)	<b>District:</b>	
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**Details of Non Medicare expenses claimed.**

NB Only forward accounts for services which are not subject to a Medicare rebate  
ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.

Are you a member of a private health fund? Yes  No

If yes, which one?

Hospital Cover Yes  No  Extras covering dental, physio, etc. Yes  No

Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)					
b)					
c)					
d)					

When did you first consult a physician for this condition?	
When did you become totally disabled (unable to work)?	
When were you able to again perform part of your occupational duties?	
If still totally disabled, when do you expect your disability to terminate?	
When will you resume training?	

Hospital	Addresses	From	To

**a.** Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

**b.** Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space.)

Name	Address	Telephone

**LOSS OF INCOME CLAIMS:**

**1. IF SELF EMPLOYED**

(Please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant?

Name	Address	Telephone

**2. IF EMPLOYED AS A WAGE EARNER**

(To be completed by your employer)

I HEREBY CERTIFY THAT:.....has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on .....

He/She has been incapacitated since.....and is expected to/did resume duties on .....

His/Her gross basic salary (excluding bonuses, commission and overtime at the date of injury was \$ ..... per week.

During this period of incapacity he/she received:

a) Normal pay \$..... b) Sick pay \$..... c) Workers Compensation \$.....  
From ..... to ..... From ..... to ..... From ..... to .....

d) Other (please specify) \$.....  
From..... to.....

He/She has been employed since.....

His/Her sick leave entitlements at date of injury is ..... days.

Name of Company: .....

Company Stamp:

Address: .....

Name of Manager or Paymaster (Please Print): .....

Signature of Manager or Paymaster: .....

Telephone: ..... Date: .....

**Loss of Income Claims (cont'd)**

Are you claiming or entitled to claim any other form of income (eg. Dept of Social Services, loss of income protection insurance, etc.)? If so, please provide details.

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**DECLARATION AND AUTHORISATION**

I hereby authorise any hospital, physician or any other person who has attended me, or any employer, to furnish QBE Insurance (Australia) Limited or its representatives with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers including verification of earnings.

I acknowledge that any personal information that I have or will provide to QBE Insurance (Australia) Limited (QBE) is necessary for and will be used in the processing, assessing, investigation or review of this claim. I consent to QBE or its authorised agent to disclose my personal information to or receive it from an investigator, assessor, surveyor, accountant, supplier, health service provider, broker, 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, QBE will provide to me their dispute resolution procedures.

I agree that a photostat 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 of Player:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(or parent/guardian if under 18 years of age)

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## Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the company)

Patients Name		Address		Sex	M/F
What is disabling patient? (Please give a complete diagnosis of this condition)					

### **HISTORY:**

1. When did patient first receive medical treatment?	
2. Was there a previous history of this or a similar condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please state condition and advise when previous treatment given.	
3. a) How long have you known the patient?	
b) Are you the regular general practitioner? If no please advise who is?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### **IF INJURY:**

1. When did patient suffer the injury?	
2. What were the circumstances surrounding the injury?	

### **IF DISABILITY:**

1. Patients occupation?	
2. When was patient obliged to cease work?	
3. If patient still disabled, when will the patient be able to commence any type of employment?	
a) some duties	b) full duties
4. If patient has recovered, when was 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 patient consulted you?		
3. Was patient confined to hospital?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please advise Hospital Name		
Address		
Period of confinement	From	To
4. Was confinement in a convalescent home necessary after hospitalisation?		Yes <input type="checkbox"/> No <input type="checkbox"/>
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 test - 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?		
Are there any underlying conditions affecting recovery from the current condition?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please advise nature of underlying conditions and how they affect disability and recovery.		
Has patient any other physical or mental impairment?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe.		
Please advise names and addresses of other treating physicians.		
Name	Address	Telephone
If you have terminated treatment, please advise 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 <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain giving estimated percentage of loss of function.		
Name (please print name):	Address:	Telephone:
<b>Signature:</b>	Degree:	Date: