Proclaim

MOTORCYCLING AUSTRALIA PERSONAL ACCIDENT INSURANCE

SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of Accidental Death or a Permanent Disability. The Schedule of Benefits is defined in the policy. The death benefit is $75,000 for members aged 18-84 years old and $10,000 for members under 18. The Benefit for Quadriplegia or Paraplegia is $150,000. Permanent Total Disability is $50,000 and Partial Disabilities are assessed on a scale to a maximum of $50,000.

Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare claimable medical expenses up to a maximum of $5,000. Claimable expenses are physiotherapy, occupational therapy, pharmacy, dental, etc, net of any entitlements from Private Health Insurance. Cover is limited to expenses incurred within 12 months from the date of injury and does not include private hospital, ambulance or any expense that is even partially claimable with Medicare.

Parents' Inconvenience Allowance

Reimburses 100% of costs incurred up to a maximum of $1,500 whilst an Insured Person under 18 years of age is hospitalised as a result of Injury including travelling, child minding and other out of pocket expenses.

Family Accommodation

Reimburses up to $125 per night for accommodation incurred when Insured Person is admitted to hospital more than 250klms from home and unable to be moved closer to home.

Student Tutorial Costs

Reimburses 100% of costs incurred up to a maximum of $250 per week for home tuition by a qualified tutor if the Injury stops the Insured Person from going to school or a tutor outside the home for up to 26 weeks with a 14 day excess period.

Home Help & Child Minding Benefit

Reimburses 100% of costs incurred up to a maximum of $250 per week for a recognised and licensed home help or child minding service if the Injury stops the Insured Person from performing his/her usual and regular duties around the home including child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 14 day excess period

Loss of Income – For Officials, Marshalls & Volunteers Only

Weekly Benefit of 100% of pre-Injury base Salary up to a maximum of $500 per week if prevented from working in your Occupation due to Injury. The benefit period is 104 weeks and the excess is 30 days.

Funeral Benefit

We will reimburse up to $2,000 for funeral expenses where the Accidental Death of the Insured Person is covered by this Policy.

Out of Pocket Expenses & Emergency Transport - For Officials, Marshalls & Volunteers Only

We will reimburse up to $1,000 for other out of pocket expenses the Insured Person incurs as a result of Injury or Disability.

Important Notes

This insurance cover is provided by MA Insurance Ltd

1. This summary of cover provides factual information about the Motorcycling Australia Insurance Program.
2. This information is only a summary of the cover provided. The full policy terms & conditions are available on Motorcycling Australia's website www.ma.org.au or by contacting Motorcycling Australia.
3. This insurance program commences on 31st December 2016 to 31st December 2019.
4. This insurance program provides benefits to those registered and licensed members of Motorcycling Australia who, through injury or accident, incur financial loss and who would otherwise not have received assistance. The program seeks to provide benefits to those most exposed and to maintain protection at the lowest possible cost to membership. It therefore cannot provide 100% cover or a benefit for every loss that occurs. Federal Government Legislation prevents insurance companies from paying any insurance benefit for a medical service that is covered by Medicare. This legislation also applies to the Medicare gap. In addition to these policies all members and officials are encouraged to take out private health insurance, ambulance cover and income protection.

Dear Motorcycling Australia member,

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 your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as you become aware that you will be making a claim. You do not have to wait until after you have completed treatment for your injury to lodge your claim form.

2. Please ensure that you fully complete pages 1 to 4 and sign and date the Authority and Declaration.

3. For claims involving Loss of Income (Marshall & Officials only):

a) You and your Employer must complete the Employment section on page 3;

b) You must attach at least two months of payslips including the most recent full period pre-Injury or if you are self-employed attach either a letter from your Accountant or your P&Ls for six months pre-Injury.

c) All Medical Certificates must be detailed, clearly stating the condition causing Disability

4. Have your treating Doctor complete the two pages under "Attending Physician's Report". This may not be completed by a physiotherapist, chiropractor or any other Allied Health provider. A Hospital Discharge Summary may also be accepted.

5. For claims involving Non-Medicare medical expenses:
a) Have your treating medical practitioner list the necessary treatment on the Attending Physician's Report as a referral. (An attending practitioner includes a general physician, other doctor or specialist or a dentist).
b) Please attach all itemised Invoices (be sure to copy them before you claim with your health fund as they will retain the original). If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

Please note:

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Commonwealth Health Insurance Act **does not permit** the insurer to contribute to any charges covered by Medicare (including the Medicare Gap.

The insurer will reimburse you for dental, chiropractic, physiotherapy, osteopath, naturopath, massage and pharmacy and for orthotics prescribed by a surgeon to aid recovery (but not those designed to aid a return to sport).

Subject to the Insurance Contracts Act 1984 cover for any treatment rendered necessary by injury can be offered for only 12 calendar months from the date of such injury occurring.

6. Once you have completed your claim form, please forward to Proclaim. They handle all claims for the insurer. Their contact details are –

Postal Address: Locked Bag 32012, Collins St East, VIC 8003

Phone: 02 9287 1302 Emails: ahclaims@proclaim.com.au Fax: 1300 858 329

7. Reimbursement will be paid to you directly by Proclaim by deposit into your nominated bank account.

8. Once your claim is registered, you can submit ongoing invoices to Proclaim. Proclaim can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

PERSONAL ACCIDENT CLAIM FORM

Thank you for notifying us of your claim - providing this form is not an admission of liability

PLEASE ENSURE

- ***You fully complete every question before your doctor completes their statement.***
- ***You have enclosed all requested information/documentation.***
- ***You have signed this claim form and provided bank details.***
- ***Your attending doctor fully completes the statement or you enclose a copy of the Hospital Discharge Summary and Referrals for Treatment.***
- ***All Medical Certificates must state the reason for your Disablement (e.g. "medical condition" cannot be accepted)***

Failure to do any of the above will result in delay in handling your claim.

CLAIMANT DETAILS

Surname:		
Given Names:		MA License Number:
Gender (please tick): ☐ Male ☐ Female	Occupation:	Date of Birth: / /
Address:		State Postcode
Email:		
Phone Number (Bus Hours): ( )	Home: ( )	
Mobile Number:		

Please tick the category applicable:-

☐ Rider ☐ Passenger ☐ Official ☐ Marshall

☐ Volunteer ☐ Other If Other, please advise_______________________________________

ACCIDENT DETAILS – To be completed by the Claimant / Rider

Describe how the accident happened?

Describe your injury (diagnosis)?

When did your accident occur?

Date: / / Time: am/pm

What **activity** were you participating in at the time of the accident?

- Coaching Clinic ( )
- Non-Competition Ride day ( )
- Club / Interclub Competition ( )
- State Championship / Open Competition ( )
- National Championship ( )
- Travelling to and from activity ( )
- Fundraising / Social event (working bee, AGM etc) ( )

Other ……

Circle the **discipline** that best describes what you were doing at the time of your accident:-

- Road Racing
- Supermoto
- Motocross
- Supercross (SX) or Arena Cross (AX)
- Dirt Track (DT) or Track
- Speedway (SP)
- Enduro or Reliability
- Trials
- Minikhana
- Quad / ATV

Tick the Box that applies:

Non Competition ( ) Competition ( )

Please provide the Track name & Address of where the injury occurred?

State the name of any one witness to the injury:

Email & Phone number of Witness:

Person to whom the accident/incident was reported? Name and Position/Title:-

Date and time reported?

Date: / / Time: am/pm

TREATMENT DETAILS - To be completed by the Claimant / Rider

Brief summary of initial treatment or action taken at the time of the accident/incident?

When did you first seek treatment following the Injury and from whom? Date: / /

Details:

Who is your usual General Practitioner? Include Clinic Name & Address	
Were you or will you be admitted to hospital?	Yes ( ) No ( )

If admitted to hospital, where and how long were you there?

1. Hospital: ____ Admitted: / / Discharged: / /

Hospital Address: ____

2. Hospital: ____ Admitted: / / Discharged: / /

Hospital Address: ____

3. Outpatient Treatment: ____

What surgical procedures were performed or are being considered?

What other treatment have you or will you likely receive:

Are you likely to make a full recovery?

Have you ever had this injury or similar injuries in the past? Yes/No	If yes, please advise when? / /

Details:

During the 24 hours before the Injury did you drink any alcohol or take any drugs? No Yes

State type/s & quantities:-

BANK ACCOUNT DETAILS

If approved, settlements will be issued by EFT. Please nominate your bank account below:

Please complete the following:

Bank: ____

Account Holders Name(s): ____

BSB Number: ___ ____ ___ --- ___ ____ ___

Account Number: ______________________________

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I____________________________________(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Proclaim, on behalf of MA Insurance Ltd, to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Proclaim on behalf of MA Insurance Ltd and their service providers in order to assess the claim. Proclaim and MA Insurance Ltd comply with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant ____ Date ____________________________
(or Legal Guardian if under 18 years of age)

Name & Relationship of Guardian: ______________________________

Relationship of Guardian to claimant: ___________________________

LOSS OF INCOME – Marshalls, Officials & Volunteers only

(ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LOSS OF INCOME) (please tick the box)	Yes	No
1. Are you entitled to make a claim for Benefits under any Act or Accident Compensation Scheme or other insurance including Loss of Income / Salary Continuance as a result of this Injury? Provide Details if Yes:		
2. Have you ever made any previous claims in respect to personal accident insurance or any other similar insurance?		
3. Have you engaged in any other income earning employment since you have been injured?		

4. Advise when did you (or when do you expect to):

Cease work: ____

Resume work:- a) Part Time or Modified Duties:- ______________________

b) Full Time/Normal Duties: ______________________

5. Describe your usual pre-Injury duties in detail:

EMPLOYER STATEMENT

- A PAY HISTORY REPORT MUST BE PROVIDED
- IF SELF EMPLOYED, PLEASE COMPLETE THESE DETAILS & SUPPLY A PROFIT & LOSS STATEMENT OR ATO NOTICE OF ASSESSMENT.

Name of Employer / Company Name:

Address of Employer: State Postcode

Date ceased work due to injury: / /	
Employee weekly salary as at date of injury: Average Gross Base Salary $................ Per week	Base salary, exclusive of overtime, allowances, bonuses & commissions Please attach a pay report for the 12 months prior to the date of Injury

Income Definition: ☐ Self Employed ☐ Full Time ☐ Part Time ☐ Casual

Has the employee returned to work? ☐ Yes ……/……/…… ☐ No

Date you current expect your Employee to resume normal duties: / /

To the best of your knowledge has or will your employee lodge any other income Claim? ☐ Yes ☐ No

Completed By:

Name:	Position/Title:
Email:	Phone Number: ( )
Salary officers signature:	Date: / /

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? ☐ Yes ☐ No

If yes, please provide details

Hospital Cover? ☐ Yes ☐ No

Extras/Ancillaries (Physio etc) ☐ Yes ☐ No

- If you have Extras cover you should claim with your Fund before submitting your expenses for consideration under this claim.

- Itemised accounts must be submitted together with details of Benefits from any Private Health Insurance.

NAME OF PROVIDER	NATURE OF SERVICE E.G Dental Physiotherapy, Prescriptions, ETC	DATE OF SERVICE / PERIOD OF HIRE	CHARGE	PRIVATE HEALTH FUND RECOVERY (IF APPLICABLE)	GAP PAYABLE
TOTAL CLAIMED:					

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

IMPORTANT

1. **THE PATIENT IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT.**
2. **This form can only be completed by the treating Medical Practitioner, GP or Surgeon**
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN - Page 1 of 2

Patient's Full Name:

How long have you known the patient?	Date of Birth:

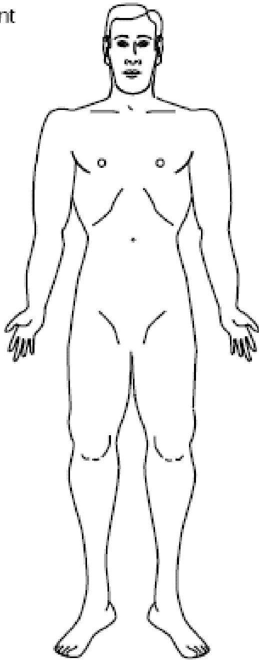
What date were you first consulted by the patient in connection with the present injury? / /

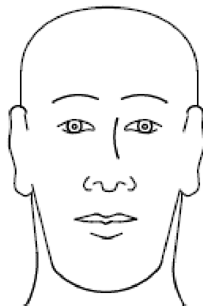
On what date was medical treatment first sought? / / With whom? ____________________

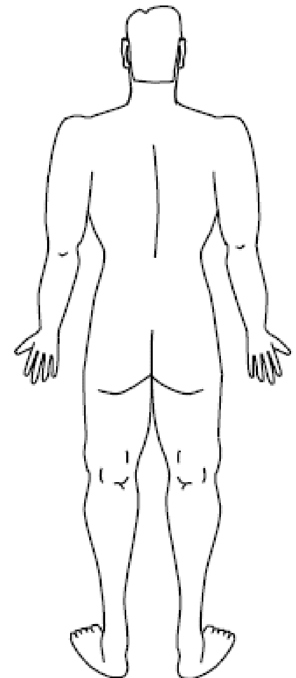
Are you the patient's regular general practitioner? ☐ Yes ☐ No

If not, please advise who is ....

What is the exact nature of the present injury? (Please detail symptoms and diagnosis and how Injury was sustained)







Do you consider the patients injury to be a new injury? ☐ Yes ☐ No

A recurrence of an old injury? ☐ Yes ☐ No

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

....

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 and approximate number of treatments required:

☐ Physiotherapy ....

☐ Chiropractic ....

☐ Other ....

Have any surgical procedures been performed? ☐ Yes ☐ No

If yes, please specify Date ……/……/……

Procedure/s:-

....

....

What surgical procedures are contemplated? ....

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

....

Is any permanent disability likely? ☐ Yes ☐ No

If yes, please explain giving estimated percentage loss of function ....

....

Will the patient benefit from assistance at home with personal care or domestic tasks, i.e. cooking, cleaning?

☐ Yes From ……/……/…… To ……/……/…… or ☐ Not necessary

Was the patient obliged to cease work? ☐ Yes From ……/……/…… ☐ No

If so, when do you expect the claimant to resume:

Some Duties ____

Full Duties ____

Does the patient have any congenital defects or chronic diseases? ☐ Yes ☐ No

If yes, please give dates, name of treating doctor and describe ....

....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital:	Date Admitted	Date Released
	/ /	/ /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name: .... Telephone Number: ( ) ....

Fax: ( ) .... Email: ....

Address:..

Signature: .... Qualifications:...

Date: ....