

AUSTRALIAN INDEPENDENT DIRT KART ASSOCIATION INC.

ACCIDENT INJURY CLAIM FORM

To assist in the speedy processing of your claim, please follow the instructions for completion of these forms and forward them to AIDKA at the above address, together with Medical Certificates and relevant receipts. Incomplete claim forms will be returned for completion, leading to assessment delays.

The issue of this form does not constitute an admission of liability on the part of the Insurer.

IMPORTANT NOTE

DO NOT forward claim forms directly to the Insurer. **Forward** all claims with a copy of your licence to the AIDKA address below.

DO NOT forward unpaid medical or ambulance accounts with Claim Forms.
All accounts should be paid and receipts forwarded with Claim Form for re-imburement.

DO NOT forward copies of accounts or receipts. All accounts and receipts should be originals.

DO NOT forward Medicare accounts.

THERE ARE THREE SECTIONS TO THIS CLAIM FORM.

Section one, CLAIMANT CERTIFICATION is to be completed by the person making the claim (injured person) and must be completed for all claims. There are three pages.

Section two, MEDICAL CERTIFICATION, is to be completed by the **registered medical practitioner** who is/or has been involved in treating the person making the claim and needs to be completed for all claims (Any fee incurred for completion of this part of the form is the responsibility of the person making the claim). There is one page.

Section three, AIDKA CERTIFICATION.

Once the injured person has completed section 1 and their treating medical practitioner has completed section 2, the injured persons needs to forward the form to AIDKA administration, who must complete section 3. There is one page.

ALL SECTIONS OF THE CLAIM FORM MUST BE COMPLETED IN FULL BEFORE A CLAIM CAN BE ASSESSED BY THE INSURERS.

When the claim form has been completed in full, signed and dated please send it, **WITH ATTACHMENTS**, to:-

A.I.D.K.A
PO Box 104
BEECHBORO WA 6063
email aidka@bigpond.com

If you have any inquiries, or if you need assistance with understanding or completing this form, you may contact AIDKA . Please ensure that you keep copies of all documentation sent to AIDKA.

All correctly completed documentation received by AIDKA will be forwarded to the insurers who will make direct contact with you.

NOTE: This form is used to initiate a claim – if you continue to be disabled – and you are claiming for loss of income - you will be sent further progress forms for completion and return on a regular basis

SECTION 1 CLAIMANT CERTIFICATION

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM

Name of Member Club or Association: _____ Track at which Accident Occurred: _____ Section _____

Competing in at time of Accident _____ **NOTE: YOU MUST ATTACH A COPY OF YOUR LICENCE**

A. TYPE OF CLAIM Which benefit are you claiming for?

() **Medical expenses**

() **Loss of income** (Note: - check with your member organisation that you have this cover)

B. YOUR DETAILS

First names: (Mr/Mrs/Ms) _____ Family Name: _____

Date of birth: ____/____/____ Medicare Number: _____

Your address _____ Suburb/town _____

Post Code _____ State _____ Occupation: _____ Telephone (H) _____ (M) _____

Driver **Official** **Mechanic** **Other (Please describe)**

Please tick appropriate box

C. THE INJURY

1. What is the injury you sustained? _____

2. Which part/s of your body were injured? _____

3. Describe **fully** how the injury occurred: _____

4. Full address of the place at which you were injured? _____

5. Were you working, or at work, or travelling to or from work at the time of the injury? _____

6. What activity were you actually engaged in at the time you were injured? _____

7. When did the injury occur? TIME _____ AM/PM DATE ____/____/____ WEEKDAY _____

8. Please nominate the name(s) and address(s) of any witnesses to your accident.

Name _____ Address _____ Ph: _____

10. Have you **EVER** previously sustained an injury to that part of your body for which you are now making this claim? _____

11. If you answered "yes" to question 10 please tell us where you were when it happened, the date and how it occurred?

(Location) _____ (Date) ____/____/____ (How it occurred) _____

12. Which doctor, hospital or medical centre, if any, did you consult on the previous occasion you were injured ?

I previously attended _____ for injury to this part of my body on ____/____/____

13. 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? _____

14. Are you claiming or entitled to claim any benefits from any other source for this injury including Workers Compensation?

Yes If Yes, which Company/Agency? _____ No

D. DETAILS OF YOUR CLAIM WITH YOUR HEALTH INSURER

What is the name of your private health fund? _____ Membership No: _____

Branch location ? _____ Have you made a claim yet? _____

2) EMPLOYEE - If YOU are an employee, contractor or sub contractor then your employer or principal contract MUST complete this section

I hereby certify that _____ has been engaged/employed by the company/business in the position of _____ since ____/____/____

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Did the person ENTIRELY CEASE WORK in their employment position?	()	()	____/____/____	____/____/____

Did the person ONLY PARTIALLY CEASE WORK in their employment position?	()	()	____/____/____	____/____/____
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Has the person now returned to FULL TIME duties?	()	()	____/____/____	/	____/____/____
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Has the person now returned to PARTIAL duties?	()	()	____/____/____	/	____/____/____
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Are there light or partial duties available within the company/business in which the person can work? _____

If so, please state what duties are available and what hours the person could be alternately engaged by the company/business _____

did he/she receive any of the following: -

- () Paid sick leave from ____/____/____ to ____/____/____ in the amount of \$_____ per week
- () Paid holiday pay from ____/____/____ to ____/____/____ in the amount of \$_____ per week
- () Workers compensation from ____/____/____ to ____/____/____ in the amount of \$_____ per week

Other (please specify) _____ From ____/____/____ to ____/____/____ in the amount of \$_____ per week

Your name: _____ Your role: _____ (Supervisor/paymaster/human resources)

Company/business name and address: _____ Telephone No: _____ Fax No: _____

Signed _____ Dated _____

IMPORTANT !

IF YOU ARE CLAIMING FOR LOSS OF INCOME YOU MUST ATTACH PROOF OF YOUR INCOME FOR THE FULL TWELVE MONTHS BEFORE YOUR DATE OF INJURY

Acceptable proof of income is a full copy of your taxation return and assessment or a PAYG summary from your employer for the twelve month period prior to the date of the injury.

SECTION 1 - CLAIMANT CERTIFICATION – CONTINUED

THIS PAGE OF THE CLAIM FORM MUST BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM

H. DECLARATION AND INFORMATION AUTHORITIES

I understand that AFA Pty Ltd may need to access, collect and disclose information about me in order to be able to assess my claim for benefits. In order to do so, I (insert your full name here) _____ of (your address) _____

hereby authorize AFA Pty Ltd to collect and disclose information about me from and to any health insurance provider, any hospital, physician, medical practice, any medical services provider, any medical therapy provider, investigators, insurance reference bureau, 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, copies of accounts. I also agree to allow access to records relating to my injury created or held by the association, university or institution at which I sustained my injury.

In providing or obtaining information about me, I understand that AFA Pty Ltd will use that information in the assessment of my claim, and that if I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd.

AFA Pty Ltd may also collect and disclose information about me to:-

- It's relevant staff and contractors and confidential service vendors involved in delivering services on behalf of AFA Pty Ltd/Australian Family Assurance Ltd.
- An agent or broker who collects the claim form from me, or who otherwise assists in facilitating the assessment of my claim
- It's re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- It's legal service providers such as legal firms, or to accountants, actuaries, providers of medico-legal services, loss adjusters, auditors, Insurance Enquiries and Complaints Ltd (IEC Ltd) and claims management consultants.

By completing and returning this form to AFA Pty Ltd, I agree to AFA Pty Ltd collecting additional information from the parties specified above in connection with the assessment of my claim and agree to AFA Pty Ltd using and disclosing my information as set out above.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I 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. The expenses which I have claimed relate solely to the injury I sustained which is the subject of this claim. I agree that if I have 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.

Signed _____

Dated ____/____/____

Signature of Parent or Guardian if claimant under 18 years old _____

Dated ____/____/____

SECTION 2 MEDICAL CERTIFICATION

THIS PART OF THE CLAIM FORM MUST BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER WHO IS CERTIFYING THAT THE INJURED PERSON IS, OR WAS, INJURED AND/OR DISABLED FROM WORKING/OR NEEDED MEDICAL CARE.

PLEASE NOTE THAT ANY FEE INCURRED FOR THE COMPLETION OF THIS MEDICAL CERTIFICATION FORM IS THE RESPONSIBILITY OF THE PATIENT

PATIENT'S DETAILS

Patient's name: _____ Date of birth: ____/____/____

1. How long has the patient been known at your practice? _____ years
2. Are you the patient's primary treating physician at your practice? _____
3. What do you understand the patient's occupation to be? _____
4. What is the medical diagnosis that is disabling the patient? _____

5. When did the patient **first** consult you in regard to this period of disability? ____/____/____
6. Is there any previous history of this or of a similar injury? _____ If so, please provide full details of the dates and the nature of the previous history of injury _____

7. If the patient sustained an injury, what were the circumstances of the injury?

8. On what date did the injury/accident occur? ____/____/____

SPECIFICS OF DISABILITY

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Has the patient been ENTIRELY PREVENTED from engaging in their occupation by the medical condition?	()	()	____/____/____	____/____/____
Has the patient ONLY BEEN PARTIALLY PREVENTED from engaging in their occupation?	()	()	____/____/____	____/____/____
Is the patient now capable of a return to FULL TIME duties?	()	()	____/____/____	
Is the patient now capable of a return to PARTIAL DUTIES ?	()	()	____/____/____	

1. If the patient is not yet capable of returning to work, what is currently preventing them from doing so? _____

2. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis

TEST	CONDUCTED ON	CONDUCTED BY	RESULT
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

9. What is the current regime of medical treatment given or required? (medication, therapies, surgery etc)

DOCTOR'S DECLARATION

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signed _____ Dated ____/____/____
Name: _____ Qualifications _____
Address _____ Telephone No: _____

SECTION 3 - AIDKA CERTIFICATION

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE AIDKA SECRETARY

1. Name of Injured Party _____ was injured as stated whilst participating in _____
Event at the _____ Track.
2. Name of Club? _____ State _____
3. Address of Club? _____
4. On what date did the Licence Holder of the insured organisation sustain injury? _____ / _____ / _____
5. Was the activity in which the member of the organisation was participating; at the time of injury, an officially authorised and sanctioned activity of the insured organisation? _____
6. What is the injured person's Licence Holder number of the insured organisation? _____
7. Was the member a fully financial Licence Holder of the insured organisation at the date of injury? _____

Declaration: I, _____ am the _____
(full name) (title of office bearer)

of the _____. I declare that the information provided in this
(name of organisation)

certification is true, correct and complete to the best of my knowledge and ability.

Signed _____

Dated: _____

NOTE:

**THE OFFICIAL OF THE ORGANISATION WHO COMPLETES THIS PAGE OF THE CLAIM FORM
MUST ATTACH DOCUMENTARY PROOF THAT THE INJURED PERSON WAS A FINANCIAL AND LICENCE
HOLDING MEMBER OF THE INSURED ORGANISATION AT THE DATE THE MEMBER WAS INJURED.**