

Office use only	
Policy Number:	
Claim Number:	

HARNESS RACING AUSTRALIA



PERSONAL INJURY CLAIM FORM



Level 17, 123 Pitt Street
Sydney NSW 2000
Phone +61 (2) 8599 8660 or 1300 172 321
Fax +61 (2) 8599 8661

Email sports@vinsurancegroup.com



INSURANCE BROKER FOR HARNESS RACING AUSTRALIA;

Authorised Representative No. 432898 a corporate authorised representative of Willis Australia Limited AFSL: 240600

Phone +61 (2) 8599 8660 or 1300 172 321

HARNESS RACING AUSTRALIA SUMMARY OF INSURANCE COVER

Death & Permanent Disablement

A lump sum benefit is payable in the event of death or a Permanent Disability. The scale of benefits is defined in the policy. The death capital benefit is \$250,000 for members aged 18-65, up to \$100,000 for members over 66 years of age (see policy for details) or \$250,000 for capital benefits other than death (\$50,000 for death) for persons 17 years and under.

Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of \$10,000. Claimable expenses are private hospital bed and theatre fee, ambulance, dental, physiotherapy etc, net of any recoveries from private health insurance – subject to a nil excess. Cover is limited to expenses incurred within 12 months from the date of injury.

Student Tutorial Costs

Reimburses up to 100% of costs incurred up to a maximum of \$500 per week for home tuition by a qualified tutor if the injury stops the Insured Person from going to their external tutor outside the home for up to 52 weeks with a 7 day excess period

Domestic Help Benefit

Reimburses up to 100% of costs incurred up to a maximum of \$300 per week for a recognised and licensed home help service if the Injury stops the Insured Person from usual and normal duties as a homemaker, sole provider for dependent children such as child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 7 day excess period

Loss of Income

Weekly Benefit 85% of earnings, if prevented from working in your occupation up to a maximum of \$1,000 per week. The benefit period is 104 weeks and the excess is 7 days. Non Harness Racing income is claimable for 52 weeks only. There is no excess applicable for loss of income claims relating to concussion. Cover also extends to include cover for additional out of pocket expenses incurred due to an injury and being unable to undertake activities related to Harness Racing, limited to a maximum reimbursement of \$1,000 per claim.

Funeral Benefit

We will pay up to an additional \$10,000 for funeral expenses in the event of the death of the insured person where the death is covered by this Policy.

Important Notes

This insurance cover is underwritten by: Canopius Australia

Australia Suite 4, Level 25, 52 Martin Place, Sydney NSW 2000

AFSL 520341 ABN 16 782 552 577

- 1. This summary of cover provides factual information about the Harness Racing Australia insurance program.
- 2. This summary of cover provides factual information about the Harness Racing Australia insurance program. The policy with full conditions is available at www.vinsurancegroup.com/hra or by contacting Harness Racing Australia.
- 3. This insurance program commenced on 1 September 2024 and expires on 1 September 2025.
- 4. V-Insurance facilitates this insurance program which provides benefits to those registered members of the Harness Racing Australia who, through injury or accident, incur financial loss and who would not have otherwise 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.
- 5. Harness Racing Australia are not and do not represent themselves as registered insurance brokers by endorsing the products outlined in this claim form.

Further details on the Harness Racing Australia insurance program can be obtained by visiting

www.vinsurancegroup.com/hra



V-Insurance Group Page 2 of 13

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 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 4, 5 and 6, please ensure you sign and date the Declaration.
- 3. For claims involving Loss of Income:
 - a) You must complete page 7 and have your employer/salary officer to complete page 7. If self-employed, you must have your accountant complete these details;
 - b) You must complete the Tax File Declaration form on page 8. If you are employed and pay tax on the income you earn (known as PAYE), the ATO requires tax to be deducted from any income that is paid to you. Personal Accident Loss of Income benefits are viewed as income earned. This declaration will be forwarded to the ATO on your behalf so that they have a record of the benefits paid to you as part of your entitlements under the Personal Accident policy.
 - c) Have your Attending Physician complete the section titled "Doctor's Statement" on pages 10 and 11.
- 4. For claims involving Non-Medicare medical expenses:
 - Medical treatment must be certified necessary by an attending physician and incurred within Australia. (An attending physician includes a general practitioner, physiotherapist, chiropractor, dentist etc).
 - a) Have your Attending Physician complete the "Attending Physician" statement on page 11.
- 5. Please attach copies of all original receipts (unless retained by your health fund). Hospital claims must be accompanied by an itemised receipt. 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 Australian Health Insurance Act does not permit the insurer to contribute to any charges covered by Medicare (including the Medicare Gap).

The insurer will pay a percentage of the amount, as indicated in the Policy schedule, for private hospital bed and theatre fees, dental, ambulance (if not otherwise covered), chiropractic, physiotherapy, osteopath, naturopath, massage and pay for orthotics prescribed by a surgeon to aid recovery.

Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 12 calendar months from the date of such injury occurring.

6. Once you have completed your claim form, please forward to V-Insurance Group;

V-Insurance Group

Level 17, 123 Pitt Street Sydney NSW 2000 Phone +61 2 8599 8660 or 1300 172 321

Fax +61 2 8599 8661

Email sports@vinsurancegroup.com

- 7. V-Insurance Group will manage your claim on your behalf and will be your point of contact. Corporate Services Network is the claims handling service that assesses claims and make payments where relevant, however V-Insurance Group will be your advocate and will be communicating with you.
- 8. Ongoing additional receipts/expenses that you incur or other correspondence relating to your injury must be sent to V-Insurance Group. Should you wish to make enquiries relating to the progress of your claim please contact us on +61 (2) 8599 8660 or 1300 172 321.
- 9. Your reimbursement cheques/EFT transfers will be paid to you directly by Corporate Services Network. Any questions relating to these payments should be directed to V-Insurance Group.
- 10. If you have any further queries relating to your claim or the cover in place, please do not hesitate to call the V-Insurance Group Team on +61 (2) 8599 8660 or 1300 172 321.



V-Insurance Group Page 3 of 13

PERSONAL ACCIDENT CLAIM FORM **CLAIMANT DETAILS** Claimant's Given Name: Surname: Member No (if applicable): Role at time of injury: Gender (please tick): Occupation: Date of Birth: ■ Male ☐ Female Address State Postcode Email Phone Number Work Home Mobile)) DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT (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 Canopius Australia 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 Canopius Australia and their service providers in order to assess the claim. Canopius Australia Insurance complies 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)



V-Insurance Group Page 4 of 13

Driver	
_	
N/Z Trainer/Driver	
Other, please advise	🗖
Stable	
Parade ring	
Stabling area at track	
Other, please advise	🗖
/ Time: am/pn	n
Officially organised race	
·	_
_	_
ARE ONLY REQUIRED IF YOU ARE CLAIMING	FOR
Address of witness:	
Date and time reported?	
·	am/pm
If yes, please advise the name of hospita	al:
Name of person who gave treatment?	
If yes, please give fund name:	
	
Resume work/normal activities	
Resume work/normal activities Resume training	
	
	Trainer Stable Hand Mini Trotting N/Z Trainer/Driver Other, please advise



V-Insurance Group Page 5 of 13

	Answering these que			
Surface at point	of injury? (please tick)	Grass Sand Bare Dirt Concrete/Bitumen Gravel Other (please advise details)	
Weather condition	ons? (please tick)		Fine Showers Rain Extreme heat Extreme cold	_ _ _ _
Type of involvem	nent when the accider	nt occurred?	Driving in race Driving at training Washing/Grooming/Stabling a horse Track/Stable maintenance Maintaining Equipment Loading/Unloading a horse Other (please advise details)	e
Sulky Type?	Not Applicable Easy Ride Sprintwell Advantage Tsunami Evolution Razor		Aerolite Aussie Eclipse Challenge Regal Vitesse Rio Other, please advise	
CLOTHING & (ONLY COMPLETE OR WORN DURING	THIS SECTION IF YOU	ARE CLAIMING FOR (CLOTHING & EQUIPMENT DAMAGED WHILS	ST BEING CARRIED
			Program's Personal Injury cover provide aged clothing or personal racing equipm	
Cover for replace	ement of damaged clo	othing or personal r	racing equipment is limited to \$1,000 pe	er claim.
Receipts - If you Services Networ		ed items and incurr	red costs, please submit your receipts to	o Corporate
DESCRIPTION OF	F DAMAGED ITEM			COST (\$)
			TOTAL	\$



LOSS OF INCOME (ONLY COMPLETE THIS SECTION IF YOU ARE CLAIMING FOR LO	OSS OF INCOME)			
(ick the box)	YES	NO
1. Can compensation be claimed under Workers Comp	ensation or any other insu	urance or		
any other insurance including Loss of Income?Have you ever made any previous claims in respect to	personal accident insuran	ce or anv		
other insurance?				
3. Have you engaged in any other income earning emplinjured?	oyment since you have be	en		
THE FOLLOWING SECTION MUST BE COMPLETED B' IF SELF EMPLOYED, PLEASE HAVE YOUR ACCOUNT			ICER.	
Name of employer:	Telephone Number:		Number:	
	()	()	
Address of employer:		State	Postco	ode
Date ceased work due to injury: / /	Date expected to resum	e normal du	uties:	1 1
Employee weekly salary as at date of injury:	Date commenced emplo	yment with	company	y :
Net \$ Gross \$	1 1			
directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self employed persons.				
Income Definition:	D. D. A.Tin			
☐ Self Employed ☐ Full Time	☐ Part Time		☐ Cas	suai
During the period of incapacity the employee has receive				
, ,		// //		
		//		
	/ to	//		
Has the employee returned to work?	Commonstier Claims	☐ Ye		
Has the employee lodged or intending to lodge a Workers	s Compensation Claim?	☐ Ye	es 🗆	NO
A. IF EMPLOYED				
Salary officer's name:	Phone Number: ()			
Salary officer's signature:	Date:	ABN/ACN:		
Company Stamp:	/ /			
Company Stamp.				
B. IF SELF EMPLOYED				
Accountant's name:	Phone Number: ()			
Accountant's signature:	Date:			
Accountant's Company Stamp:	/ /			
Accountant's Company Stamp.				



V-Insurance Group Page 7 of 13

ADDITIONAL EXPENSES

Please list any additional expenses you have incurred as a result of your injury.This could include paying someone to train your horse (if you are a trainer), or drive your horse (if you are a trainer/driver). Expenses must be agreed to by the insurer and official receipts produced. Limited to a maximum reimbursement of \$1,000 per claim.

NAME OF SERVICE PROVIDER	SERVICE PROVIDED	DATE OF SERVICE	AMOUNT CHARGED
	•		
	•		
	_		
	•		
		TOTAL	



V-Insurance Group Page 8 of 13



Tax file number declaration

This declaration is NOT an application for a tax file number.

■ Use a black or blue pen and print clearly in BLOCK LETTERS.
■ Print **X** in the appropriate boxes

YOU ONLY NEED TO COMPLETE THIS PAGE IF YOU ARE CLAIMING LOSS OF INCOME (refer page 3, 3b)

Γ	ato.gov.au Print X in the appropriate	including the privacy statement before you complete this declaration.	٦
	ection A: To be completed by the PAYEE What is your tax	6 On what basis are you paid? (Select only one.)	
•	file number (TFN)?	Full-time Part-time Labour Superannuation or annuity employment mire income stream	
	For more information, see question 1 on page 2 OR I have made a separate application/enquiry to the ATO for a new or existing TFN. OR I am claiming an exemption because I am under	7 Are you an Australian resident for tax purposes? (Visit ato.gov.au/residency to check) No	=
	of the instructions. 18 years of age and do not earn enough to pay tax.	8 Do you want to claim the tax-free threshold from this payer?	
_	OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance.	Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.	
2	What is your name? Title: Mr Mrs Miss Ms Surname or family name	Yes No No No except if you are a foreign resident in receipt of an Australian Government pension or allowance.	,
	First given name	9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?	
	Other given names	Yes Complete a <i>Withholding declaration</i> (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions.	
		10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you	?
3	If you have changed your name since you last dealt with the ATO, provide your previous family name.	Yes Complete a Withholding declaration (NAT 3093).	
		11 (a) Do you have a Higher Education Loan Program (HELP), Student Start- Loan (SSL) or Trade Support Loan (TSL) debt?	up
4	What is your date of birth? Day Month Year Vear	Yes Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment.	_
5	What is your home address in Australia?	(b) Do you have a Financial Supplement de \[\] Your payer will withhold additional amounts to cover any compulsory \[\]. \[\]	_
		Yes repayment that may be raised on your notice of assessment.	
		DECLARATION by payee: I declare that the information I have given is true and correct. Signature Date	
	Suburb/town/locality	You MUST SIGN here	_
	State/territory Postcode	There are penalties for deliberately making a false or misleading statement.	_
Г	Once section A is completed and signed give it to your power to comp		
_	Once section A is completed and signed, give it to your payer to compection B: To be completed by the PAYER (if you are n		
1	What is your Australian business number (ABN) or Branch number	4 What is your business address?	
	withholding payer number? (if applicable) 3 0 0 7 4 8 6 4 6 0 9 0 0 4		
2	If you don't have an ABN or withholding payer number,		
	have you applied for one? Yes No	Suburb/town/locality	_
3	What is your legal name or registered business name	State/territory Postcode	
	(or your individual name if not in business)?	5 Who is your contact person?	
		ANTHONYROUHANA	
		Business phone number 0 2 8 2 5 6 1 7 7 0	
_		6 If you no longer make payments to this payee, print X in this box.	
	ECLARATION by payer: I declare that the information I have given is true and correct. gnature of payer	Return the completed original ATO copy to:	
	Date Day Month Year	Australian Taxation Office PO Box 9004 PENRITH NSW 2740 PREUITH the Completed original ATO copy to: See next page for: payer obligations lodging online.	
	There are penalties for deliberately making a false or misleading statement.		
		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). ☐ Yes Are you a member of an Ambulance Service? ☐ No ☐ Yes Are you a member of a Private Health Fund? ■ No If yes, please provide details Hospital Cover? ☐ Yes ☐ No ☐ Yes ☐ No Extra's covering, Physio etc Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance. NAME OF PROVIDER NATURE OF SERVICE DATE OF **CHARGE** PRIVATE HEALTH AMOUNT **FUND RECOVERY CLAIMABLE SERVICE EG DENTAL** (IF APPLICABLE) PHYSIOTHERAPY ETC Total **Less Excess TOTAL AMOUNT OF CLAIM** If claiming physiotherapy or other specialist treatment, please provide the name and address of referring doctor:







Office use only	
Policy Number:	
Claim Number:	

AR No. 432898 Willis Australia Limited AFSL: 240600 Phone +61 (2) 8599 8660 or 1300 172 321 Completed claim forms should be sent to V-Insurance Group, Level 17, 123 Pitt Street, Sydney NSW 2000 or via email sports@vinsurancegroup.com

SPORTS INJURY ATTENDING PHYSICIAN'S REPORT

DOCTOR'S STATEMENT (PLEASE PRINT LEGIBLY)

IMPORTANT

- 1. The patient is responsible for any fee for this statement.
- 2. This form can <u>only</u> be completed by the treating Medical Practitioner, Surgeon or Physiotherapist.
- 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 PHYSICIA	N
Patient's Full Name:	How long have you known the patient?
What date and where were you first consulted by the patient in o	connection with the present injury?
Are you the patient's regular general practitioner? Yes If not, please advise who is	□ No
What is the exact nature of the present injury?	
Front () () () () () () () () () (Head



V-Insurance Group Page 11 of 13

Do you consider the patient's 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 g	given		
Have you referred the patient to any other services or to	reatment?	☐ Yes	☐ No	
Please specify the type and approximate number of treating the specify the type and approximate number of treating the specific treating the specific treating to any other services of the specific treating the specific treating the specific treating treating the specific treating t			■ NO	
	•			
Physiotherapy				
☐ Chiropractic				
☐ Other				
Have any surgical procedures been performed? If yes,	please specify			
What surgical procedures are contemplated?				
Are there any further remarks which may assist in asse	ssing this conditi	ion?		
	3			
Is there any permanent disability at present?		Yes	☐ No	
If yes, please explain giving estimated percentage loss	of function			
Was the patient obliged to cease work?		Yes	☐ No	
If so, when do you expect the claimant to resume:	Some Duties			
	Full Duties			
What date do you advise the patient to return to harnes	s racing?			
Described to the control of the cont				
Does the patient have any congenital defects or chronic		☐ Yes	☐ No	
If yes, please give dates, name of treating doctor and d	escribe			
If the patient has been hospitalised, please give name of	•	-		
Name of Hospital: Date	e Admitted		Released	
•	/ /	/	1	
CERTIFICATION BY ATTENDING PHYSICIAN				
			inion the statement	to model in
I hereby certify I have personally examined the above r the Accident details section of this claim form are consi				its made in
	•	-		
Name:	Telephone Nur	nber: ()	
Fax: ()	Email:			
Fax: ()	EIIIaii			
Address:				
				••••••
Signature:	Qualifications:			
Date:				



V-Insurance Group Page 12 of 13

METHOD OF PAYMENT
Should a benefit be payable for this claim then you have a choice of receiving your payment by cheque or Electronic Funds Transfer (EFT) to a nominated bank account
Please indicate your preferred method of payment (please tick)
If you would like your payment made by EFT, please complete the details below.
NAME OF CLAIMANT
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Name:
BANK ACCOUNT DETAILS
BSB number (all 6 digits are required here) Account Number
Nominated account name:
Bank, Credit Union, Building Society name:
Branch:
DECLARATION
DECLARATION I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds
DECLARATION I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply: • I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this
 DECLARATION I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply: I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment. Corporate Services Network is not responsible for any delays in payment or errors due factors outside its
 DECLARATION I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply: I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment. Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details. I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network's disclosure of this information, to Canopius Australia's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the <i>Privacy Act 1988</i>. I understand that my failure to supply full details and to sign this declaration may result in my
 DECLARATION I hereby authorise Corporate Services Network to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account. I understand and agree that the following conditions will apply: I agree that the payment is made when Corporate Services Network has instructed its bank to credit the nominated account and that we release Corporate Services Network from any further liability in relation to this payment. Corporate Services Network is not responsible for any delays in payment or errors due factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details. I agree to Corporate Services Network collecting, holding and maintaining the following personal information to authorise payments to my nominated bank account. I agree to Corporate Services Network's disclosure of this information, to Canopius Australia's bank and my bank for the purpose and administration of processing my payment. I understand that I have the right to access or correct my personal information under the <i>Privacy Act 1988</i>. I understand that my failure to supply full details and to sign this declaration may result in my payment not being paid or my payment being paid into a wrong account. I declare that the details in this application are true and correct and (where applicable) I am authorised on



V-Insurance Group Page 13 of 13