

SOCCER CASE REPORT

Injured: Player Referee Official Coach Other: _____
 Name: _____ Age: _____ Male Female
 Address: _____
 City: _____ State: _____ Postcode: _____ Phone: _____
 Team Name: _____ League _____
 Name: _____

INJURY/DAMAGE:

Date of Injury: _____
 Injured Body part: _____
 Condition: _____
 (Sprain, fracture, concussion etc)

TIME:

Morning
 Afternoon
 Evening

DISPOSITION:

On site care only
 Ambulance to: _____
 City: _____
 Fatality

PLAYER POSITION	ACTIVITY	SITUATION
<input type="checkbox"/> Goal Keeper	<input type="checkbox"/> Attacking	<input type="checkbox"/> Tackling
<input type="checkbox"/> Fullback	<input type="checkbox"/> Defending	<input type="checkbox"/> Blocked
<input type="checkbox"/> Midfielder	<input type="checkbox"/> Kicking	<input type="checkbox"/> Being Tackled
<input type="checkbox"/> Forward	<input type="checkbox"/> Blocking	<input type="checkbox"/> Being Blocked
<input type="checkbox"/> Sweeper	<input type="checkbox"/> Coaching	<input type="checkbox"/> Hit by Ball
<input type="checkbox"/> Stopper	<input type="checkbox"/> Officiated	<input type="checkbox"/> Ran into _____
	<input type="checkbox"/> Goal Keeping	<input type="checkbox"/> Altercation
	<input type="checkbox"/> Refereeing	<input type="checkbox"/> Tripped
	<input type="checkbox"/> Passing	<input type="checkbox"/> Kicked
	<input type="checkbox"/> Training	<input type="checkbox"/> Ran into by Player
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

OCCASION:	LOCATION:	SURFACE CONDITION:
<input type="checkbox"/> Before Match	<input type="checkbox"/> On the Field	<input type="checkbox"/> Normal
<input type="checkbox"/> During Match (_____ period)	<input type="checkbox"/> In the Goal	<input type="checkbox"/> Wet
<input type="checkbox"/> After Match	<input type="checkbox"/> Sidelines	<input type="checkbox"/> Irregular
<input type="checkbox"/> Practice	<input type="checkbox"/> Indoor Court	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Spectator Area	
	<input type="checkbox"/> Other: _____	

PROGRAMME:	PENELTY CALLED:	ESTIMATED ABSENCE FROM SOCCER:
<input type="checkbox"/> Preseason Training	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less than 1 week
<input type="checkbox"/> Preseason Trail	<input type="checkbox"/> On opponent	<input type="checkbox"/> 1 – 3 weeks
<input type="checkbox"/> Preseason Competition	<input type="checkbox"/> On Injured Player	<input type="checkbox"/> More than 3 weeks
<input type="checkbox"/> Regular season match	<input type="checkbox"/> On Both	
<input type="checkbox"/> Final series match	Describe hoe accident happened: _____	
<input type="checkbox"/> Representative match	_____	
<input type="checkbox"/> Indoor soccer match	_____	
<input type="checkbox"/> Dribble n Kick	_____	

Signature of person other than claimant or parent who can attest to injury: _____

Print Name: _____ Ph: _____

1. IF SELF EMPLOYED

Please attach proof of earnings over past 12 months immediately preceding injury (net of business expenses, but before income tax and personal deductions eg Tax return:

Who is your Accountant?

Name: _____

Address: _____

Postcode: _____ Ph: _____

1. 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/illness suffered whilst _____

On ____/____/____.

* He/she has been incapacitated since ____/____/____ and is * expected to/did resume duties on ____/____/____

* his/her average gross weekly income at the date of injury of the 12 months immediately preceding injury (excluding bonuses, commission, overtime or any other weekly allowances) \$ _____ per week

During the period of incapacity, he/she received :

*\$ _____ Normal Pay From ____/____/____ To ____/____/____

*\$ _____ Sick Pay From ____/____/____ To ____/____/____

*\$ _____ Worker's Comp From ____/____/____ To ____/____/____

*\$ _____ Other _____ From ____/____/____ To ____/____/____

Has been employed since ____/____/____

NAME OF COMPANY: _____

SIGNATURE OF SUPERVISOR/ PAYMASTER: _____

NAME OF SURPVISOR/PAYMASTER (please print): _____

PH: _____ DATE ____/____/____

**TO BE COMPLETED BY CLUB SECRETARY/TREASURER, THEN FORWARD TO GROUP SECRETARY FOR SIGNING.
PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED**

_____ was injured as stated whilst playing _____

Grade with the club on the ____/____/____

NAME OF CLUB: _____

SECRETARY/TREASURERS NAME: _____

ADDRESS: _____

DAYTIME PH: _____ MOBILE: _____

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

SIGNATURE: _____

WITNESS: _____

*INSERT GRADE APPLICABLE: _____ GROUP SECRETARY: _____

Insert if applicable in space provided any further information relevant to insured player's injury.

HAS/DID THE PLAYER RETURNED TO PLAY? Yes No

IF NOT PLEASE ADVISE THIS OFFICE AS SOON AS PLAYER RESUMES PLAYING SPORT.

ATTENDING PHYSICIAN'S STATEMENT

THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO
THE COMPANY

The attending physician's statement must be completed by a qualified medical practitioner such as a Doctor, and not a physiotherapist etc

Reference No: _____ Policy No (with prefit): _____

Sex: Male Female Age: _____

Patient's Name & Address: _____

What is disabling patient? _____

Please give a complete diagnosis of this condition: _____

HISTORY

1. when did patient first receive medical treatment? _____

2. a) Was there a previous history of this or similar condition? Yes No

b) If YES please state condition and advise when previous treatment was given: _____

3. a) How long have you known this patient? _____

b) Are you the regular General Practitioner? Yes No If NO, who is? _____

IF INJURY:

1. When did patient suffer from the injury? _____

2. What are the circumstances surrounding the injury? _____

IF SICKNESS:

1. When was sickness first contracted? _____

2. When did symptoms become evident? _____

DEGREE OF DISABILITY:

1. Patient's Occupation: _____

2. When was patient obligated to cease work? _____

3. If patient is disabled, when approximately will patient be able to resume:

a) Some duties? _____

b) Full duties? _____

OR

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 No

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

If YES, give details: _____

5. What are the current subjective symptoms? _____

6. Please give results of any objective findings: _____

a) X-rays

b) Other tests – Please advise tests done & findings 1) _____

2) _____

7. What surgical procedures have been performed? 1) _____

2) _____

8. What surgical procedures have been contemplated? 1) _____

2) _____

9. What other treatment has patient undergone? _____

10. What other treatment is required? _____

Are there any underlying conditions affecting recovery from the current condition? Yes No

If Yes, please advise nature of underlying conditions and how they affect disability and recovery: _____

Has patient any other physical or mental impairment? Yes No

If yes, please describe: _____

Please advise names and addresses of other treating physicians: _____

What is the current prognosis? _____

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

Is there any permanent disability at present? Yes No

If yes, please explain giving estimated percentage loss of function: _____

Signature: _____ Date: ____/____/____ Degree: _____

Name (please print): _____

Street Address: _____

City: _____ State: _____ Ph: _____

DISCLOSURE STATEMENT AND PRIVACY CONSENT

SLE Worldwide Australia Pty Limited (SLE) is committed to protecting the privacy of the personal information you provide to us.

We will use the personal information requested on this form to enable us to consider your claim. We may also need additional information in connection with your claim from the Health Insurance Commission, any hospital, physician or other person who has or will be attending you and your past or present employer/s. We may also need to collect additional information from claims investigators or surveillance officers if your claim is investigated by us.

If you do not provide us with this information, we may not be able to process your claim.

We may disclose your personal information we collect on this form and any other additional information we collect in relation to this claim:

- To our relevant staff and contractors involved in delivering our services;
- If a broker collects the claim form for you, to that broker (this is applicable to the claim form only);
- To your employer;
- To your sports association to confirm your eligibility to claim under a policy arranged by it;
- To the insurer, underwritten for certain underwriters at Lloyds or London by their agent SLE Worldwide Australia Pty Limited;
- To reinsurers or reinsurance brokers (which may include reinsurers located outside Australia);
- To facilitators such as legal firms, accountants, actuaries and loss adjusters employed by us to assist us to consider your claim;
- To consultant doctors and physicians (in connection with the handling of your claim);
- To claims investigators and surveillance officers (in circumstance where the claim is investigated by us);
- If required to do so by law enforcement body or by law; and

You may request access to your personal information we hold about you and where necessary correct any errors in this information (some restrictions and costs may apply).

By completing and returning to us this form and agreeing to us collecting additional information from the parties specified above in connection with your claim, you agree to us using and disclosing your information as set out above.

This consent to the us and disclosure of your personal information remains valid unless you alter or revoke it by giving us written notice.

If any of your personal information changes in the future, please notify us of these changes so we can ensure that the information we hold to you is accurate, complete and up to date.

I agree that the Photostat copy of this document shall be considered as effective and valid as the original and specifically authorise its use as such.

Name: _____

Player Signature: _____ Date: _____

Parent/Guardian (under 18's): _____ Date: _____



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ELECTRONIC BANKING DETAILS TO BE COMPLETED BY INSURED PERSON

Please provide account details to ensure prompt payment of your benefits.

PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US

Name of Bank/Credit Union/Building Society, etc: _____

Branch: _____

Account in name of: _____

Type of account: _____

BSB No: _____

Account No: _____

I / We, (please print) _____ declare
and warrant that the above particulars are true and correct in every detail.

Further, I / We authorise SLE Worldwide Australia Pty Limited to credit this account with any monies payable to me under the Policy of Insurance.

I shall notify SLE Worldwide Australia Pty of any changes to the above details immediately in writing.

Please NOTE only an original document will be accepted (a photocopy will NOT be accepted).

NAME: _____

SIGNED: _____ DATE: _____