Network INSURANCE GROUP | Steadfast THE STRENGTH YOU NEED

Australian Sailing

Summary of Insurance Cover

Network Steadfast

G.W.S. Pty Ltd - Trading as Network Insurance Group

ABN: 20 000 669 778 | AFS Licence: 231210

North Sydney 02 9957 2544 Melbourne 03 8420 8700 Tuggerah 02 4350 1200

Australian Sailing Summary of Insurance Cover

(*This is a summary of cover only. Please refer to the policy wording for full terms, conditions and exclusions.)*

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 benefit is $75,000 for members aged up to 85 years old and $10,000 for members under 18.

Non Medicare Medical Expenses

Reimburses up to 100% of Non-Medicare medical expenses up to a maximum of $5,000 subject to a $50 excess. Claimable expenses are private hospital bed and theatre fee, ambulance, net of any recoveries from private health insurance. Cover is limited to expenses incurred within 12 months from the date of injury.

Physiotherapy Benefit

Reimburses between 75% to 95% of costs incurred up to a maximum of $30 - $45 per visit up to a maximum of $750. Cover is limited to expenses incurred within 12 months from the date of injury.

Student Tutorial Costs

Reimburses up to 80% of costs incurred up to a maximum of $300 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 80% 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 dependant children such as child-minding, cleaning, cooking, school pick up and drop offs for up to 52 weeks with a 7 day excess period.

Broken Bones

We will pay up to $5,000 any one accident. Cover only applies if the event occurs within twelve (12) calendar months of the date of Injury. Please refer to the policy wording and Certificate of Insurance for details of the cover provided and policy limits.

Dental

We will pay up to $5,000 any one accident. Cover only applies if the event occurs within twelve (12) calendar months of the date of Injury. Please refer to the policy wording and Certificate of Insurance for more details of the cover provided and policy limits.

Loss of Income

Weekly Benefit 100% of pre-Injury Salary, if prevented from working in your Occupation up to a maximum of $300 per week. The benefit period is 52 weeks and the excess is 7 days.

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 AIG Australia Limited ("AIG Australia")
ABN 93 004 727 753 | AFSL 381686

1. This summary of cover provides factual information about the Australian Sailing Insurance Program.
2. This information is only a summary of the cover provided. The policy with full conditions is available by contacting Australian Sailing or their Insurance Brokers

Australian Sailing:
Locked Bag 806, Milsons Point, NSW 1565
Level 1, 22 Atchison St, St Leonards, NSW 2065
Tel: 02 8424 7400
www.sailing.org.au

Network Steadfast:
PO Box 877 Collins Street West, Melbourne ,VIC 3000
Level 35, 140 William Street, Melbourne, VIC 3000
Tel: 03 8420 8777
Email: admin@networksteadfast.com.au
www.networksteadfast.com.au

3. This insurance program commences on 1 October 2021 to 30 June 2022.
4. This insurance program provides benefits to those registered members of Australian Sailing 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.

How to Make a Claim

Dear Australian Sailing 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 or rejection of your claim.

1. Only one claim form (per injury) is required. A claim form should be completed and submitted as soon as reasonably possible 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 5 & 6 and sign and date the Declaration.
3. Please ensure that your Association/Club official completes and signs the Association/Club Declaration on page 5.
4. For claims involving Loss of Income:
    a. You must complete page 7 and have your employer/salary officer complete page 8. If self-employed, you must have your accountant complete these details;
    b. You must attach at least two pay slips including the most recent full period pre-Injury.
    c. Have your Attending Physician complete the “Attending Physician” statements on page 7 & 8. If claiming under Section 2: Physiotherapy benefit, this form may be completed by a Physiotherapist only if claiming for five visits or less.
5. For claims involving Non-Medicare medical expenses:

Have your treating practitioner complete the “Attending Physician” statement on page 8 & 9 making sure all Medical treatment is certified necessary by your attending practitioner and incurred within Australia. (An attending practitioner includes a general physician, other doctor or specialist or a dentist).

6. Please attach all itemised receipts (be sure to copy them before you claim with your health fund as they will retain the original). Hospital claims must be accompanied by an itemised Invoice, not just the estimate. If treatment or a cost incurred 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, Anesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Law in Australia does not permit the insurer to contribute to any charges covered by Medicare (including the Medicare Gap). Subject to the applicable legislation, 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.

7. Once you have fully completed all sections of the claim form, please have your Association/Club complete and sign page 5 and confirm your injury occurred during a sanctioned activity.
8. Once you have completed your claim form, please forward to AIG Australia Limited. Their contact details are: Address: GPO Box 9933 Melbourne VIC 3001 Australia Email: austclaims@aig.com Phone: 1800 812 363.
9. Any indemnity will be paid to you directly by AIG Australia Limited by deposit into your nominated bank account.
10. Once your claim is registered, you can submit ongoing invoices to AIG Australia Limited. We can also be reached on the above contact details should you wish to make enquiries relating to the progress of your claim.

Claim Form:
Australian Sailing Sporting Personal Injury Insurance

Section 1: Claimant Details

Claimants Name: _____ Date of Birth: _____

Club Name: _____ Member No: _____

Occupation: _____ Gender: _____

Address: _____ Postcode: _____

Email: _____ Phone: _____

Please tick the category applicable: Participating Member ☐ Official ☐

Sailing Course Participant ☐ Volunteer ☐ Other (Please Specify) ☐

_____

_____

Event or other activity:_____

Name of Team / Age Group / Grade:_____

Section 2: Declaration Agreement and Authorisation by Claimant

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. 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 or my policy may be cancelled. I hereby authorise AIG Australia Limited to collect and disclose information about me or the parties referenced in the privacy notice below 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 any taxation returns and assessments.

Privacy notice

AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including data analytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Failure to disclose information required may result in AIG not being able to administer or declining the claim.

AIG may disclose your information to:

- your or our agents, AIG related entities, reinsurers, contractors or third party providers providing services related to the administration of the claim;
- assessors, third party administrators, emergency providers, retailers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim;
- entities to which AIG is related and third party providers for data analytics functions; and
- Government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

Some of these entities may be located overseas, including in United States of America, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which you have a claim and such other countries as may be notified in our Privacy Policy from time to time.

Our Privacy Policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicable privacy principles and how AIG will deal with such a complaint.

Consent

I consent to AIG collecting, using and disclosing personal information as set out in this notice. If I have provided or will provide information to AIG about any other individuals, I confirm that I am authorised to disclose his or her personal information to AIG and also to give this consent on both my and their behalf.

Signature of Claimant (Or Legal Guardian if Under 18 years of age)_____

Date_____

Declaration by Association

Name of Association/Club:_____

Name of Official Making this Statement:_____

Official's Position:_____Phone:_____

Email:_____

Address:_____Postcode:_____

Do you have any comments in relation to this claim?_____Yes / No_____

If yes, please specify:_____

_____

_____

☐ I, the above mentioned Australian Sailing or Club Official, confirm that the claimant was a registered and Financial member of this club at the time of the accident, that the information contained in this statement is true and correct, and

to the best of my knowledge and belief the information referred to in this claim form is true and correct. ☐ I, confirm that the claimed accident occurred at an Australian Sailing Affiliated club premises, including an organised event; OR at an event that was organised by or sanctioned by World Sailing or one of World Sailing's Member National Authorities, including but not limited to Australian Sailing.

The claimed accident did not occur whilst participating in an event or on the premises of a non-affiliated Australian sailing club.

Signature of Association/Club Official:_____

Date:_____

Section 3: Accident Details (To be completed by the claimant)

Describe how the accident happened:_____

_____

Describe your
Injury:_____

_____

When did your accident Occur?_____Date:_____Time:_____am/pm

What was your activity at the time of the Incident? (Please Tick) Officially Organised Training ☐

Officially Organised Competition ☐ Social or Private Competition ☐

Sanctioned fundraising / social event ☐ Travelling to and from activity ☐

Please provide the address of where the injury occurred:_____

_____Postcode:_____

State the name of any one witness of the injury:_____

Address of Witness:_____

_____Postcode:_____

Person to whom accident was reported:_____

Date and time reported?_____Date:_____Time:_____am/pm

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

_____

Was hospitalisation required?_____Yes / No_____

If yes, please advise name of the hospital?_____

If admitted into hospital, how long were you there?_____

Name of person who gave treatment:_____

Advise below when you did (or expect to):

Cease work/normal activities: _____ Resume work/normal activities: _____

Cease training: _____ Resume training: _____

Cease participating: _____ Resume participating: _____

Have you ever had this injury or similar injuries in the past?_____Yes / No_____

If yes, please advise when:_____

Provide details:_____

_____

Section 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).

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:_____

Do you have hospital cover? _____Yes / No_____

Are you covered for Extras incl. Physio etc? _____Yes / No_____

Itemised accounts and receipts must be submitted together with details of Benefits from any Private Health Insurance

Name of provider	Name of Service (i.e. dental)	Date of Service	Charge	Private Health Fund Recovery (if applicable)	Amount Claimable

Section 5: Loss of Income (only complete this section if claiming for loss of income)

Can compensation be claimed under worker's compensation

Or any other insurance including Loss of Income?_____Yes / No_____

Have you ever made any previous claims in respect to personal

Accident insurance or any other similar insurance?_____Yes / No_____

Have you engaged in any other income earning employment

Since you have been injured?_____Yes / No_____

The following section must be completed by your employer/salary officer. If self employed, please have your accountant complete these details.

Name of employer:_____ Address :_____

_____Postcode:_____

Phone:_____Fax:_____

_

Date ceased work due to injury:_____

Date expected to resume normal duties:_____

Employee weekly salary as at date of injury: Average Gross Base Salary $_____Per Week_____

Base salary, exclusive of overtime, allowances, bonuses & commissions If self-employed, provide average weekly salary based on 12 month period directly prior to injury. A copy of your latest taxation return is also to be provided as proof of earnings for self-employed persons.

Date commenced employment with company:_____

Income definition: (Please Tick) Self Employed ☐ Full Time ☐ Part Time ☐ Casual ☐

During the period of incapacity the employee has received:

$_____ Normal Pay _____ From: _____To: _____

$_____ Sick Pay _____ From: _____To: _____

$_____ Workers Compensation ___ From: _____To: _____

$_____ Other _____ From: _____To: _____

If other, please

specify_____

_____

Has the employee returned to work?_____Yes / No_____

Has the employee lodged or intending to lodge a Workers' Compensation claim?_____ Yes / No_____ **A- If Employed**

Salary Officers Name:_____

Company Stamp:

_____

Phone:_____

Email:_____

ABN/ACN:_____

Salary Officers Signature Date:_____

A- If Self Employed

Salary Officers Name:_____

Company Stamp: _____

Section 6: Attending Physician Statement

Important:

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon (A physiotherapist may complete if claiming 5 visits or less under Section 2: Physiotherapy benefit).
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**

Patient's Full Name: _____ Date of Birth: _____

Are you the patient's General Practitioner? _____ Yes/No

_____

If not, name of usual medical doctor:_____

How long have you known the patient?_____

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

On what date did the patient first seek medical treatment for the present injury:_____ Name of first treatment provider for present injury:_____

Do you consider the patient's injury to be a new injury? _____ Yes/No _____

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

_____

_____

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:

Type Physiotherapy ☐ Chiropractic ☐ Other (Details) ☐

_____

Number of Treatments Physiotherapy ☐ Chiropractic ☐ Other (Details) ☐

Have any Surgical Procedures been performed? _____ Yes/No _____

If yes, please specify:_____

Have any Surgical Procedures been contemplated? _____ Yes/No _____

Any further remarks which may assist in assessing this condition:_____

Is there a 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 _____

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 _____

Section 7: Certification by Attending Physician

Name: _____ Qualifications: _____

Email: _____

Phone: _____ Fax: _____

Address: _____ Postcode: _____

Signature: _____ Date: _____

Section 8: Method of Payment

Should a benefit be payable for this claim, payments will be made by Electronic Funds Transfer (EFT) to a nominated bank account.

BANK ACCOUNT DETAILS – Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: _____ Account Number: _____

Section 9: Declaration

I hereby authorise AIG Australia Limited 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 AIG Australia Limited has instructed its bank to credit the nominated account and that we release AIG Australia Limited from any further liability in relation to this payment.
- AIG Australia Limited is not responsible for any delays in payment or errors due to factors outside its reasonable control, including delays or errors in the financial system or errors in the supplied account details.
- I agree to AIG Australia Limited collecting, holding and maintaining my personal information to authorise payments to my nominated bank account. I agree to AIG Australia Limited disclosure of this information, to my bank for the purpose and administration of processing my payment.
- 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

Signature: _____

Name (Print): _____ Date: _____

Section 10: Claim Lodgement Details

Please forward claim details using one of the following lodgement processes

(Please keep a copy of all documents sent to Network Insurance Group)

Postal Address: PO Box 577, Collins Street West Melbourne VIC 8007 Australia Email: claims@networksteadfast.com.au