



WESTERN AUSTRALIAN
**CHRISTIAN FOOTBALL
ASSOCIATION**

Form 10 – Injury Report (Must be completed with seven days of Injury)

This report is **mandatory** for all injuries to players/officials/volunteers, sustained during a WACFA match or club training event that may result in an insurance claim.

The steps for reporting and making an insurance claim for an injury are as follows:

1. Club Representative:
Complete this form (form10) on behalf of person who sustained the injury (must be within seven days of the injury) and send this form to the Office Administrator of WACFA. (see contact details on form header)
2. Injured Person:
Submit all claimable accounts to Medicare such as x-rays, ultrasound etc, and Private Health Fund for claims such as physio, dental etc.
3. Club Representative:
If requested, send injured person a copy of the full claim form (issued by insurance company).
4. Club Representative:
Complete the detailed claim form in conjunction with the injured person and medical practitioners and forward this to Insurance Company (address details provided on the form) within 30 days of the injury. (also provide a copy to WACFA admin)
5. Injured Person:
Continue your treatment and forward ORIGINAL itemized accounts and receipts to Insurance Company when available.

Injury Claim Notes:

1. The issue of this form does not constitute an admission of liability on the part of the insurer or the association.
2. Government legislation does not allow refund of any part of a Medicare expense, which is doctor, surgeon, Anaesthetist, X-Ray and pathology.
DO NOT SEND ANY MEDICARE ACCOUNTS.
3. Claims without referral from a medical practitioner or dentist following injury will be denied.

*This form must be **completed** and a copy sent to the Office Administrator of WACFA within seven days of the injury.*

Form 10 – Injury Report :

| | |
|------------------------------|--|
| Reporting Date: | |
| Club Name: | |
| Club Contact Name: | |
| Contact Phone Number: | |

Injured Person:

| | |
|--------------------------------|--|
| Name of Injured Person: | |
| Address | |
| Home Phone | |
| Mobile | |
| Email address | |
| Date of Birth | |
| Gender (Male/Female) | |

Injury Details:

| | |
|---|--|
| Date and Time of Injury: | |
| Venue where the injury occurred (address): | |
| Details of incident and injury: | |
| Doctor Attended | |
| Hospital Attended | |
| Ambulance Attended | |

Details of Club Representative Completing this Form:

| | |
|-------------------------|--|
| Name | |
| Address | |
| Home Phone | |
| Mobile | |
| Email address | |
| Relationship | |
| Position in Club | |

| | |
|-------------------|--------------|
| Signature: | Date: |
|-------------------|--------------|

Where to send this Form:

| | |
|--------------------------------|--|
| To | WACFA Office |
| Postal Address | WACFA, Po Box 41, Thornlie Post Shop, Thornlie, WA, 6988 |
| Email (scanned copy) to | admin@wacfa.com.au |

Insurance Company Contact Details (if required):

CLAIMS HOTLINE: 1300 134 956
EMAIL: asiapac.claims@sportscover.com

Please send all claims correspondence to:

CLAIMS DEPARTMENT
SPORTSCOVER AUSTRALIA PTY LTD
Locked Bag 6003
Wheelers Hill VICTORIA 3150