IMPORTANT
This form must be completed by the claimant.

MA INSURANCE LIMITED

When completed please return this form to **Proclaim**:
Phone Number: 02 9287 1302
Mail: Locked Bag 32012, Collins St East, VIC 8003
Fax Number: 1300 858 329

Motor Sport Personal Accident Claim Form

INJURED PERSON'S STATEMENT TO COMPANY

Important notice: Every question must be answered fully. Incomplete answers and vague information may delay processing of your claim. Please print answer or tick box as required.

Personal Details

Surname
Given Names
Address
State | Postcode
Email
Telephone No Home | Mobile

Occupation Trade or Profession | Date of Birth

Accident Details

Were You: Rider ☐ Passenger ☐ Pit Crew ☐ (If pit crew, Name of Rider)

Marshal ☐ Official ☐ (If official, state your title)

Class Competed in | MA Licence no.
Name of your Club | Licence Type
Date of Accident / /
Track Where Injury Occurred | Time of Accident am/pm
Address
State | Postcode
Track Licence no.
Event Permit no.

Was Track: Wet ☐ Dry ☐ Tyres: Slicks ☐ Grooved ☐ Off Road ☐

Were there any witnesses to the accident? Yes ☐ No ☐ If 'Yes' Give Details (Name & Address**)**
....
....

Injuries suffered:(Detail your Injuries) . . . .
....
....

Brief Statement of How Accident Happened:
....
....
....
....

Treatment

Was Hospital Treatment required? Yes ☐ No ☐

Hospitals – If you were admitted to hospital, or treated as an out-patient please give details.

	Name	Address	From - To
a) Inpatient	a)	a)	a) -
b) Outpatient	b)	b)	b) -

	Doctors Name	Address	Telephone (If Known)
Give details of all attending doctors	1.	1.	1.
	2 .	2.	2.
	3.	3.	3.

When did you first obtain treatment from a doctor? Time [am/pm] Time [/ ./]

When did you stop work? Time [am/pm] Time [/ /]

Name of current Doctor
Address
State Postcode

Are you still being treating for the injury? Yes ☐ No ☐

What **treatment** have you or will you receive:

Is this doctor your regular doctor? Yes ☐ No ☐

Regular Doctor's Name
Address
State Postcode

Is there any condition (past or present) affecting you current disability? Yes ☐ No ☐

If 'Yes' give details:

……
……
……
……
……

If approved, settlement will be issued by EFT. Please nominate your bank account below:

BSB Number: ___ ___ ___ - ___ ___ ___

Account Number: ______________________________

Account Holder's Name: ____

Current State of Injury

Recovered ☐ Partially Disabled ☐ Totally Disabled ☐ Fatality ☐

When will you / do you expect to return to work? ____ / ____ / ____

Have you made or are you entitled to make a claim for benefits under Workers' Compensation, any Act or Accident Compensation Scheme or other Insurance as a result of this Injury? Yes ☐ No ☐ If 'Yes' give details:

	Name	Contact Details & Claim Number
Employer		
Insurer		

Are you entitled to claim benefits from any Health Fund, Friendly society? Yes ☐ No ☐ If 'Yes' give details

Fund Name ______

If so, what benefits will can you claim? i.e. Hospital, Extras or Ancillaries? ______

Employment (Applicable for Marshalls and Officials only)

1. If Self Employed

Please attach proof of earnings over the past 12 months (e.g. Tax Return or letter from you accountant)

Who is your Accountant?

Name ______

Address ______

State ______ Postcode ______ Telephone Number ______

2. If Employed as a wage earner

What are your gross average weekly earnings? $ ______

Please attach proof (eg. Pay History Report for 12 months pre-Injury, Letter from employer)

Who is your Employer?

Name ______

Address ______

State ______ Postcode ______ Telephone Number ______

Period of Employment From ______ To ______

Authority

I hereby authorise any medical practitioner or other person who has attended to me to furnish Motorcycling Australia Insurance Limited or their solicitors and/or loss adjustors acting on their behalf and/or their duly accredited representatives, including Proclaim Management Solutions, all information with respect to this injury, any medical history, prescriptions or treatment and copies of all hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original.

Signature of Injured Person or Representative ………………………………………………. Date ……/……/20……

Name of Injured Person or Representative …………………………………………………………………… (Please Print)

If Representative, Relationship to Injured Person: ……………………………………………………………………

Declaration

I/We declare that the information supplied on this form and in any attached documentation is true and correct and that I/We have not withheld anything material from the company.

Signature of Injured Person or Representative ……………………………………… Date ..…/..…/20……

NB: The Medical Certificate on Page 4 Must be Completed

Medical Statement (to be furnished at the expense of the claimant)

	Patient's Name:	
1	Nature and Extent of Injuries (Final Diagnosis):	
2	When did you first see the claimant in respect of this injury?	
3	When did the patient first seek Medical Attention and from whom?	
4	(a) When did the Injury occur?	(a)
	(b) How did the Injury occur?	(b)
5	(a) When did you last see the claimant?	(a)
	(b) Will you be seeing the claimant again in respect of their current injuries?	(b)
6	Are the injuries consistent with the description of circumstances given by your patient?	
7	Has the claimant ever suffered this or any similar Injury previously? Please provide details	
8	Is the patient now, or were they at the time of sustaining the injuries suffering from or affected by any other physical infirmity, disease or illness or are they suffering from or has he suffered from any cardiac condition, gout, rheumatism, or fits of and kind? If so, give particulars.	
9	(a) Are you aware of anything in the claimant's medical history which might have contributed to their injuries or which is in any way likely to retard their recovery?	(a)
	(b) Is the injury likely to recur and cause further disablement?	(b)
10	Please detail any treatment or surgery the claimant has undergone and any future treatment recommended:	
11	(a) Has the claimant at any time, as the result of the injuries been medically unfit to engage in or attend, in a material degree to their profession, business or occupation?	(a)
	(b) If So, From What date?	(b) / /
	(c) When was/will the claimant be medically fit to engage in or attend to their profession, business or occupation?	Partially Fit …………………………………… Completely Fit ………………………………

I Certify that I have examined the above mentioned person, and I have read the answers given by him to the questions on the front hereof which appear to be in accordance with the present appearance of the injuries, and I further certify that there are no other circumstances except……………………………………………………………………………………tending to produce either total or partial disablement.

Date: …………………. ....………… Signature of Doctor: ………………………………………………………………………

Name(PleasePrint):………………………………………………Qualifications:……………………………………………………...

Address:……………………………………………………………Postcode:……………………Phone:……………………