



**SLE Worldwide Australia Pty Limited**

ABN 15 066 698 575 Licence No: 237268

Level 11, 56 Clarence Street, Sydney NSW 2000

PO Box H308, Australia Square NSW 1215

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[www.sleaustralia.com.au](http://www.sleaustralia.com.au)

# MOTOR SPORT CASE REPORT



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IN CASE OF SERIOUS INJURY, CALL 1-800-002676

Insuring the world's fun...  
Level 11, 56 Clarence Street, Sydney NSW 2000  
PO Box H308, Australia Square NSW 1215

(Tick and/or circle one per section, complete relevant blanks.)

<b>INJURED:</b> (Driver) (Pit Crew) (Official) (Spectator) (Other): _____	<b>Event:</b> Track Name: _____
Name: _____	Track City: _____
Category: <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five	Race Name: _____
Address: _____	Race Type: _____
City: _____ State: _____ Post code: _____	Vehicle Type: _____
Phone: ( ) _____ Age: _____ Sex: (M) (F)	Email Address: _____

INJURY/DAMAGE:	TIME:	DISPOSITION:
DATE OF INJURY: _____	<input type="checkbox"/> Morning	<input type="checkbox"/> On-Site Care Only
INJURED BODY PART: _____	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Ambulance to: _____
CONDITION: _____ (Sprain, Fracture, Concussion, etc.)	<input type="checkbox"/> Evening	<input type="checkbox"/> City: _____
	<input type="checkbox"/> Fatality	<input type="checkbox"/> Refused treatment

**OCCASION**

PRACTICE  
 PRE RACE-PREPARATION  
 QUALIFYING RUN/TRIALS  
 DURING RACE  
 DURING RACE/YELLOW FLAG  
 BETWEEN RACES  
 AFTER RACES  
 NON-RACE BUSINESS  
 OTHER: \_\_\_\_\_

**LOCATION:**

GARAGE AREAS  
 PITS (Entrance) (Exit)  
 START/STAGING AREA  
 TURN # \_\_\_\_\_  
 STRAIGHTWAY  
 GRANDSTAND  
 OTHER: \_\_\_\_\_

**ACTIVITY:**

RACING  
 TO/FROM PITS  
 VEHICLE MAINTENANCE/REPAIR  
 LOADING/UNLOADING  
 OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SITUATION**

HIT BY RACER  
 HIT RACER  
 HIT FENCE/WALL  
 HIT BY DEBRIS  
 (Log/Rock) (Vehicle Part)  
 FELL (Slip) (Trip) (Pushed)  
 OTHER: \_\_\_\_\_

**SPECIAL CIRCUMSTANCES:**

LOST WHEEL  
 CUT TYRE  
 BLOWER LIFTED  
 BLOWN ENGINE  
 STUCK THROTTLE  
 WET TRACK  
 OTHER: \_\_\_\_\_

**ESTIMATED ABSENCE FROM RACING:**

LESS THAN 1 WEEK  
 1-3 WEEKS  
 MORE THAN 3 WEEKS  
 NOT APPLICABLE

DESCRIBE HOW ACCIDENT HAPPENED: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of person other than claimant who can attest to injury: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_



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## 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 number: \_\_\_\_\_ Policy Number (with prefix): \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_

Patient's name and 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 the patient? \_\_\_\_\_

(b) Are you the regular general practitioner?  Yes  No If not, please advise who is: \_\_\_\_\_

**IF INJURY:**

1. When did patient suffer the injury? \_\_\_\_\_

2. What were 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 obliged to cease work? \_\_\_\_\_

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

(a) Some Duties? \_\_\_\_\_

OR (b) Full Duties? \_\_\_\_\_

4. If patient has recovered, when was patient able to resume:

(a) Some Duties? \_\_\_\_\_

(b) Full Duties? \_\_\_\_\_

GO TO "TREATMENT OF PRESENT CONDITION".

**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

If yes, please advise 1. Name and address of hospital: \_\_\_\_\_

2. Period of confinement: From: \_\_\_\_\_ To: \_\_\_\_\_

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: \_\_\_\_\_

1. X-Rays

2. Other tests - please advise tests done and findings: 1. \_\_\_\_\_

2. \_\_\_\_\_

7. What surgical procedures have been performed? 1. \_\_\_\_\_

2. \_\_\_\_\_

8. What surgical procedures are 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: \_\_\_\_\_

If you have terminated treatment, please advise date: \_\_\_\_\_

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 or Town: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

COMPLETE AND RETURN AS SOON AS POSSIBLE TO:



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## SPORTING ACCIDENT REPORT FORM

NAME OF CENTRE/CLUB	NAME OF TEAM OR AGE GROUP	REGISTRATION NUMBER	STATE ASSOCIATION
PLAYER'S FULL NAME	ADDRESS	CITY	STATE POST CODE
DATE OF BIRTH	HEIGHT AND WEIGHT	SEX	TELEPHONE
NORMAL OCCUPATION PRIOR TO DISABLEMENT		DESCRIBE USUAL DUTIES	
1. Give full description of injury from which you are now suffering. State when, where and how it happened.  2. (a) Have you ever had this, or a similar condition, in the past? (b) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics.	<input type="checkbox"/> INJURY  HOW SUSTAINED FULL DESCRIPTION:  <input type="checkbox"/> YES    CONDITION(S): <input type="checkbox"/> NO      DATES: TREATED BY:	<input type="checkbox"/> YES <input type="checkbox"/> NO    TRAINING <input type="checkbox"/> YES <input type="checkbox"/> NO    COMPETITION WHERE: _____	
3. (a) Give exact date when injury occurred: (b) When did you first consult a physician for this condition? (c) When did you become totally disabled (unable to work)? (d) When were you able to again perform part of your occupational duties? (e) When were you able to again perform all of your occupational duties? (f) If still totally disabled, when do you expect your disability to terminate? (g) When will you resume training?		(a) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (b) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (c) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (d) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (e) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (f) Date: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (g) Date: _____	
4. Hospitals (Give complete names, addresses and dates of admission and discharge).	NAMES	ADDRESSES	FROM TO
5. (a) Give names addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE
(b) Give names addresses and telephone numbers of usual family physician.	NAME	ADDRESS	TELEPHONE
6. What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of sickness or injury and names and addresses of all treating doctors, hospitals and clinics).	NATURE OF SICKNESS OR INJURY	NAMES	ADDRESSES
7. Are you now, or have you ever been subject to or affected by any other injury or disease deformity defect of senses infirmity or weakness? If so, give details.			
8. Do you hold Private Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Membership Number and Branch _____	Have you claimed yet? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### ELECTRONIC BANKING DETAILS TO BE COMPLETED BY THE INSURED PERSON

**PLEASE DOUBLE CHECK ALL DETAILS BELOW BEFORE SUBMITTING TO US**

Branch: \_\_\_\_\_

Account in the Name of: \_\_\_\_\_

Type of Account: \_\_\_\_\_

BSB Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

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 Limited to credit this Account with any monies payable to me under the Policy of Insurance.

**I/We shall notify SLE Worldwide Australia Limited of any changes to the above details immediately in writing.**

Name (please print): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**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 e.g. Tax Return)

Who is your Accountant:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

**2. 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/Injuries/Sickness 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 for the 12 months immediately preceding injury. (excluding bonuses, commission, overtime or any other allowances) \$ \_\_\_\_\_ p.w.

During the period of incapacity, \*\$ \_\_\_\_\_ Normal Pay from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ he or she received

\*\$ \_\_\_\_\_ Sick Pay from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\*\$ \_\_\_\_\_ Workers' Comp from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\*\$ \_\_\_\_\_ Other (please specify) from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Has been employed since \_\_\_/\_\_\_/\_\_\_

NAME OF COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POSTCODE: \_\_\_\_\_

SIGNATURE OF SUPERVISOR OR PAYMASTER: \_\_\_\_\_

NAME OF SUPERVISOR OR PAYMASTER (please print): \_\_\_\_\_

TELEPHONE NUMBER: ( ) \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

**TO BE COMPLETED BY A WITNESS CLUB SECRETARY/TREASURER**

**PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED.**

\_\_\_\_\_ was injured as stated.

NAME OF CLUB OR ASSOCIATION: \_\_\_\_\_

WITNESS/SECRETARY/TREASURER'S NAME: \_\_\_\_\_ PHONE NUMBER: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

MEMBERSHIP NUMBER (if applicable): \_\_\_\_\_

**"IMPORTANT"**

This form must be completed by the injured party and then forwarded on to the Club/Track Official (Secretary) for signature and approval. Club/Track must then forward on to the address above.

## 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 to collect 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 from 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 of 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 circumstances where the claim is investigated by us);
- if required to do so by a 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 use 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 about you is accurate, complete and up-to-date.

I agree that a photostat copy of this document shall be considered as effective and valid as the original

Name .....

Signature .....

Date ...../...../.....

**WITNESS:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ POST CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_

AH PHONE: \_\_\_\_\_

**WITNESS:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ POST CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_

AH PHONE: \_\_\_\_\_

**COMMENTS:**

**COMPLETE ALL INFORMATION. FOLD IN HALF AND TAPE.**

**PLACE  
PROPER  
POSTAGE  
HERE**

**SLE WORLDWIDE AUSTRALIA PTY. LIMITED**  
LEVEL 11, 56 CLARENCE STREET, SYDNEY NSW 2000  
PO BOX H308, AUSTRALIA SQUARE NSW 1215