# Accidental Injury Benefit Application Form

## Section 1: Personal and Accidental Injury Details

Injured person or their legal representative to complete.

Full Name of Injured Person xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Street Address xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Email address xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Business Phone (Area code) [ ]xxxxxxxxxxxxxxx Mobile Phone [ ]xxxxxxxxxxxxx x

Date of Birth\* / / Weight Height (cms) Gender: xxxxxxxxxx x

\*Please provide proof of age and identity

Occupation prior to Accident xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Describe your usual occupational duties

|  |
| --- |
|  |

Describe the Outcome and Benefit for which you are applying

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If the application is for Outcome 2-9, are you also applying for the education Benefit and/or the emergency transportation Benefit? If also applying for the emergency transportation Benefit please provide details of the associated ACC transport claim.

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Describe the injury for which you are claiming the Benefit and how this resulted in the Outcome

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|  |

On what date did your injury occur? / /xxxx

What were you doing at the time?

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| --- |
|  |

Have you ever suffered a similar injury in the past? Yes / No x

If yes, give full details of the injury, its severity and the nature of any resulting incapacity:

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| --- |
|  |

When did you first consult a doctor for the injury for which you are applying?

Date / /xx Time AM/PM

When did you become totally disabled for work?

Date / /xx Time AM/PM

Give details below of all attending doctors and hospitals attended.

Date of consultation/Treatment / /xxxx

Name of hospital xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Name of Doctor xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx

Phone [ ]xxxxxxxxxxxxxxx

Address/Email xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxx

Date of consultation/Treatment / /xxxx

Name of hospital xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Name of Doctor xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Phone [ ]xxxxxxxxxxxxxxx

Address/Email xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Name of Your usual Doctor Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Phone [ ]xxxxxxxxxxxxxxx

Address/Email Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

\*If there are more than two consultations/treatments, please include the details of these on a separate page and submit with your application.

## Section 2: Declaration – Authority & Privacy Consent

If you are signing on behalf of the injured person, please state your authority to do so and relationship.

Please print your name and contact phone:

Name x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx Phone [ ]xxxxxxxxxxxxxx Position of Authority to sign – Nature of Relationship

x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

**Declaration**

I/we (print name/s) x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx x

declare that the answers above, and those contained in any attachments are true and accurate and note that these answers may be relied on in determining any Benefit.

I/we have not concealed any material fact relating to my application for a Benefit.

I/we undertake to provide reasonable assistance, as requested by NZR when it is determining whether I am eligible for a Benefit and understand that failure to co-operate and to provide all information relating to my application for a Benefit may result in my/our application being denied.

**Authority**:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish New Zealand Rugby, its representatives or other third parties with:

**I.** copies of hospital and medical reports/notes considered relevant to the application;

**II.** copies of employment records and tax returns that may be relevant to the application; and

**III.** information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) which may be relevant to the application.

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

**Privacy:**

I/we consent to New Zealand Rugby in accordance with the Privacy Act 1993:

1. collecting holding and using personal information, provided for purpose of administering an application including investigating, assessing and paying any application made by me or on my behalf;

2. disclosing personal information submitted to law enforcement agencies, investigators, lawyers, assessors, advisors, and the agent of any of these or intermediary, employer for the purpose of administering my application.

Information is provided voluntarily however if we do not collect this information, we may not be able to assess an application.

Injured persons have rights of access and correction to their personal information under the Privacy Act.

NOTE: New Zealand Rugby will only seek information which in its opinion it believes to be relevant to this application and investigation of my eligibility for the Benefit.

Name: xxxxxxxxxxxxxxxxxxx xxx

Signature: xxxxxxxxxxxxxxxxxxxxxx Date: / /xxxx

## If NZR determine that I am eligible for a Benefit, I would like the Benefit paid to me by this account

Payee Name: xxxxxxxxxxxxxx xxx xx x

Account Number xx xx xx xx xx xx xx xx xx xx xx xx xx xx xx xx

## Section 3: Sports Injury Application

To be completed by the Club Secretary / Treasurer.

Name of Club xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Secretary / Treasurer’s Name xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Phone [ ]xxxxxxxxxxxxxxx

Address/Email Address xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

I certify that xxxxxxxxxxxxxxxxxxxxxxxxxx was injured on / /xx while:

\*Please select one and only one option below by inserting a tick or a cross next to the best description of when the injury was suffered

|  |  |
| --- | --- |
| Indicate Here |  |
|  | 1. Engaged or playing in an official match or activity, including championship or representative matches or activities. |
|  | 1. Engaged in official organised training or practice for official matches or activities described in the row above. |
|  | 1. Engaged in official organised pre-season training or practice within New Zealand. |
|  | 1. Travelling, directly and uninterrupted, between their place of residence or employment and any matches, activities, training or practice described in an of the three rows above which they were required to engage in. |
|  | 1. Engaged in official speaking or speaking engagements for an NZR affiliated sporting organisation to which they belong. |
|  | 1. Staying away from their home district during a tour for the purpose of participating in representative matches or activities and when engaged in official organised activities of that tour. |
|  | 1. None of the above – please describe what was happening when the injury was suffered: |

Grade xxxxxxxxxxxxxxxxxxxxxxxxxx

Name: xxxxxxxxxxxxxxxxxxxxxxxxxx Position: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Signature: xxxxxxxxxxxxxxxxxxxxxxxxxx Date: / /xxxx

## Section 4: Attending Doctor’s Statement

Please print clearly. If there is insufficient space for any answers please attach a separate sheet.

Patient’s Name x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxx Age x xxxxxxxxxxxxxx x

**Medical Condition**

Diagnosis: x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx x

Any Complications? Yes / No x

If yes give details

|  |
| --- |
|  |

**Injury**

When did the accident occur? / /xxxx

What bodily injury resulted from the accident?

|  |
| --- |
|  |

Has injury described above resulted in any residual disability? Yes / No x

If yes, please give full details and provide copies of specialist or other reports

|  |
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|  |

What are the factors causing injury that is related to the application?

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| --- |
|  |

What is the expected or known permanence of the injury

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| --- |
|  |

Can you confirm that the injury resulted from an accident and was not associated with any other cause including any pre-existing physical or congenital conditions.

|  |
| --- |
|  |

When did patient first receive medical attention for the injury? / /xxxx

By whom? x xxxxxxxxxxxxxx xx Qualifications x xxxxxxxxxx xxxx

Dates discharged from your care / /xxxx OR

What treatment is proposed ongoing? x xxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx x

**Hospitalisation**

Dates hospitalised: Admitted/Discharged x xxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Name and location of hospital x xxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx x

What operation if any was performed? x xxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Were there any other doctors or consultants attending? Yes / No x

If insufficient space please attach separate sheet

Name x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxx Speciality xxxxxxxxxx Address/Email x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxx x Phone [ ]xxxxxxxxxxxx x

**Prognosis / Extent of Disability:**

***Occupational Duties:***

Based upon patient’s occupation of (if applicable) x Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

or any business, employment, occupation or profession for which they are reasonably qualified by reason of education, training or experience:

a. Has the patient been able to do ANY work? Yes / No x

b. If so from what date?

Full duties / /xxxx Restricted Duties / /xxxx

If not, when will they be able to work?

Full duties / /xxxx Restricted Duties / /xxxx

***Daily Activities:***

Has the patient been able to perform the following daily activities:

\*For each daily activity below please indicate whether the patient is able to perform these, based on the definitions included, by writing “Yes”/“Y” or “No”/”N”

|  |  |
| --- | --- |
| Indicate Here |  |
|  | **Washing** – the ability to wash in the bath or show (including getting into and out of the bath or shower). |
|  | **Dressing** – the ability to put on and take off, secure and unfasten all garments. |
|  | **Getting between rooms** – the ability to get from room to room on a level floor. |
|  | **Feeding themself** – the ability to feed themself when food and drink has been prepared. |
|  | **Maintaining personal hygiene** – the ability to maintain a satisfactory level by using the toilet or otherwise managing bowel and bladder functions. |

***Prior History***

Are you the usual family doctor for this patient? Yes / No x Since what date? / /xxxx

Has patient ever had the same or a similar condition previously? Yes / No x

Date / /xxxx Condition x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Were you the treating physician? Yes / No x

If not please give name and contact details of the other Treating Physician

Name x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxx Phone [ ]xxxxxxxxxxxxxx

Address x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxx

Email x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxx xxx

**Prior Defects**

Does the patient have any defects or chronic conditions? Yes / No x

If yes, describe x xxxxxxxxxxxxxx xxxxxxxxxxxxxxx x originating around / /xxxx

Your name x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xx

Your Qualifications: x xxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxx

Phone [ ]xxxxxxxxxxxxxxx

Email Address xxxxxxxxxxxxxx xxxxxxxxxxxxxx xxx xx x

Name: xxxxxxxxxxxxxxxxxxxx x

Signature xxxxxxxxxxxxxx xxxxxxxxxxxxxx xxx xx x

Date / /xxxx