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

Street Address

Email address

Business Phone (Area code) [ ] Mobile Phone [ ]

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

*Please provide proof of age and identity

Occupation prior to Accident

Describe your usual occupational duties

Describe the Outcome and Benefit for which you are applying

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.

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

On what date did your injury occur? / /

What were you doing at the time?

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

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

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

Date / / Time

When did you become totally disabled for work?

Date / / Time

Give details below of all attending doctors and hospitals attended.

Date of consultation/Treatment / /

Name of hospital

Name of Doctor

Phone [ ]

Address/Email

Date of consultation/Treatment / /

Name of hospital

Name of Doctor

Phone [ ]

Address/Email

Name of Your usual Doctor

Phone [ ]

Address/Email

**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 | Phone [ ]

Position of Authority to sign – Nature of Relationship

Declaration

I/we (print name/s)

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: _____

Signature: _____ Date: / /

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

Payee Name: _____

Account Number ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

Section 3: Sports Injury Application

To be completed by the Club Secretary / Treasurer.

Name of Club	
Secretary / Treasurer's Name	
Phone	[ ]
Address/Email Address	

I certify that _____ was injured on / / 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.
◯	2. Engaged in official organised training or practice for official matches or activities described in the row above.
◯	3. Engaged in official organised pre-season training or practice within New Zealand.
◯	4. 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.
◯	5. Engaged in official speaking or speaking engagements for an NZR affiliated sporting organisation to which they belong.
◯	6. 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.
◯	7. None of the above – please describe what was happening when the injury was suffered:

Grade			
Name:		Position:	
Signature:		Date:	/ /

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 | Age

Medical Condition

Diagnosis:

Any Complications? Yes / No

If yes give details

Injury

When did the accident occur? / /

What bodily injury resulted from the accident?

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

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

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

What is the expected or known permanence of the injury

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? / /

By whom? Qualifications

Dates discharged from your care / / OR

What treatment is proposed ongoing?

Hospitalisation

Dates hospitalised: Admitted/Discharged

Name and location of hospital

What operation if any was performed?

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

If insufficient space please attach separate sheet

Name Speciality

Address/Email Phone [ ]

Prognosis / Extent of Disability:

Occupational Duties:

Based upon patient's occupation of (if applicable)

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

b. If so from what date?

Full duties / / Restricted Duties / /

If not, when will they be able to work?

Full duties / / Restricted Duties / /

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 Since what date? / /

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

Date / / Condition

Were you the treating physician? Yes / No

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

Name Phone [ ]

Address

Email

Prior Defects

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

If yes, describe originating around / /

Your name

Your Qualifications:

Phone [ ]

Email Address

Name:

Signature

Date / /