Please return completed form to Lacrosse Victoria within 7 days of the incident.  
Lacrosse Victoria will arrange for Claim forms to be forwarded to the player by the Insurance Company.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | | | |
| **Given name** | |  | | | | **Surname** | |  | | |
| **Address** | |  | | | | | | | | |
| **Suburb** | |  | | | | **Post Code** | |  | | |
| **Phone** | |  | | | | **Mobile** | |  | | |
| **Lacrosse Club** | |  | | | | | | | | |
| **Current financial member** (If No, club fees are required to be paid within 7 days for claim to be processed) | | | | | | | | | | Yes  No |
| **Injury Details (circle where appropriate)** | | | | | | | | | | |
| **Nature of event** | | Training Game Other | | | | | Grade: | | SL A B U17 U15 U13 U11 | |
| **Team** | |  | | | | | Venue | |  | |
| **Time** | |  | Date: | | / / | | Type: | | Player Coach Official | |
| **Description of Incident** | |  | | | | | | | | |
| **Resultant Injury** | |  | | | | | | | | |
| **Details of First Aid Provided** | |  | | | | | | | | |
| **Names of two Witnesses: (coach, team manager, committee member)** | | | | | | | | | | |
| **1** |  | | | | | | | | | |
| **2** |  | | | | | | | | | |
| **Player Signature** | | | |  | | | | | | |
| **If U18; Parent/Guardian Signature** | | | |  | | | | | | |

Excess medical/hospital expenses are only payable after Medicare and Private Health insurance (if applicable) rebates have been paid.

Club to keep a copy of this form.