TOOWOOMBA COMMUNITY FOOTBALL

Medical Expenses Claim Form

Details of Claimant

Name: ____ Date of Birth: _____________________

Team Affiliation: ________________________________ TCF Member Number: ______________

Address: ____

Contact Phone Number: ____________________________

Details of Injury

Date of Injury: _________________ Location: ____

Description of Event that Led to the Injury: ____

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Description of Injury: ____

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Disclaimer (please tick the box to indicate your agreement with each statement)

☐ I acknowledge that I read and signed the Player Registration Form in full informing me that Football is a contact sport where injuries may occur and that TCF does not have comprehensive insurance cover protecting me from all costs associated with injuries incurred while playing football with TCF.

☐ I acknowledge that the injury described above was incurred at or during the TCF event or match described above.

☐ I understand that TCF will only reimburse me for out of pocket medical expenses upon submission of medical invoices or receipts. I understand that the amount that TCF will reimburse me for is up to but not exceeding $500 of the combined total of the medical invoices or receipts and that only one Medical Expenses Claim Form may be submitted per injury-sustaining event.

☐ I understand that TCF will only reimburse me for medical invoices or receipts that are related to the injury occurred at the TCF event or match described and dated above. TCF will not reimburse me for out of pocket expenses occurred due to loss of income.

☐ A copy of the medical invoices or receipts that I am seeking reimbursement for are outlined below and are attached to this form.

Printed Name: ______________________________ Signature: __________________ Date: ______________

Details of the Medical Invoices or Receipts Submitted

Provider	Date of Initial Payment	Cost

Bank Details for Reimbursement to be paid into

Account Name:	Bank:
BSB:	Account Number:

TCF Use Only

The above claim has been: **Accepted** **Rejected**

If Claim has been rejected, the reason for this decision is: ______________________________________

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Date of Payment made: ____________________________________

Name of Authorised TCF Person: ______________________________

Signed: _________________________________ Date: ______________________________