

**GOGANS SPORTS PERSONAL ACCIDENT INSURANCE SCHEME**

**SECTION A – CLAIMANT & CLUB DETAILS**

**NAME OF CLAIMANT**

**NAME OF CLUB**

**FULL ADDRESS OF CLAIMANT**

**FULL ADDRESS OF CLUB**

**DATE OF BIRTH**

**TEAM GRADE**

**MOBILE NUMBER**

**EMAIL ADDRESS**

**EMPLOYMENT STATUS**

Student     Employed     Self-Employed     Not in Employment

**OCCUPATION**

**PRIVATE MEDICAL INSURANCE DETAILS – PLEASE ENSURE TO TICK BOX APPLICABLE TO YOU**

Aviva Health     VHI     Laya     GloHealth     None

Other

**The Gogans Sports Personal Accident Insurance Scheme only provides cover for non-recoverable costs up to the limit specified under the scheme. If you have medical insurance, a claim must be made with your Medical Provider.**

**Therefore you must supply a statement of account or letter confirming you are not covered for your medical costs from your medical provider. Failure to supply same will delay the assessment of your claim.**



**SECTION B – INJURY DETAILS**

DATE OF INJURY

TIME OF INJURY

LOCATION  
(Address)

**AMOUNT BEING CLAIMED**

Medical Expenses

Prescribed Physio

Loss of Wages

**EXACT NATURE  
& CIRCUMSTANCE  
OF INJURY (HOW PRECISELY  
DID THE INJURY OCCUR)**

Where did the injury occur? Club Training  Challenge Match   
Official Game  Other (specify)

Were you wearing Protective headgear at the time? Yes  No

If No, please explain why:

**ALL BENEFITS WILL BE HALVED IN THE EVENT THAT PROTECTIVE HEAD GEAR IS NOT WORN**

**Claimant's Declaration**

I hereby declare that to the best of my knowledge the foregoing statements are true in every respect.

I hereby authorise the doctor / dentist / physiotherapist / hospital / employer / Private Health Insurer / Dept. of Social Protection (or equivalent) to supply any information requested. I understand that any deliberate misstatement will void the claim in its entirety.

I consent for the purposes of the Data protection Acts, 1988 and 2003 to the information I give on this form and any other form issued to me in connection with this claim and to any other information that I give in relation to this claim being held and assessed by Aviva.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Aviva in assessment of this claim.

To whom should the Settlement be made payable to

Relationship to the Claimant

Claimants Name (BLOCK CAPITALS)

Claimant's Signature

Date

**NATURE OF YOUR CLAIM**

**Medical / Dental / Physio Expenses**

**Permanent Disability**

Non recoverable medical expenses up to policy limit **excluding** the excess shown on the certificate of cover for each and every claim.

**Loss of Wages (ONLY COVERED IF NOTED ON YOUR POLICY)**

In Relation to Claims for Loss of Earnings, please note the following:

Applicable to all Insured Persons over 18 years who are in full time employment working a minimum of 16 hours per week and is only payable if you are unable to work due to injury received in the course of playing/training the designated sport.

This Benefit shall pay for otherwise unrecoverable loss of basic net wage excluding overtime, bonuses and unsociable working hours and shall be payable for 52 weeks **excluding** the first four weeks.

Social Welfare shall be considered as recoverable income and will be deducted from the basic net wage figure.

Benefit is payable for each complete week (7 consecutive days) and no Benefit shall be payable for partial weeks.

Special Condition Applying to Benefit 6 Loss of Wages (Temporary Total Disablement)

The maximum benefit payable is as follows:

Weeks 1 to 4	Nil
Weeks 5 to 52	up to €350.00

**SECTION C – LOSS OF WAGES CERTIFICATE – FOR COMPLETION BY A SELF-EMPLOYED CLAIMANT**

**NAME OF YOUR COMPANY**

**ADDRESS OF YOUR COMPANY**

**BUSINESS DESCRIPTION**

**NATURE OF EMPLOYMENT**

**REASON FOR LOSS OF INCOME**

**Amount of Average Weekly Net Income**

€

**Weekly Net Wage Paid to Substitute Workers**

€

**I declare that I am unfit for work following injury as a result of participating in a match / training and unable to earn by average weekly income.**

**I attach**

- (i) **Confirmation of my loss of net weekly wages from my accountant (include Chartered Accountant Registration number)**
- (ii) **Details of my claim with the Department of Social Protection (or equivalent)**

**Signature**

**Date**

**SECTION D – LOSS OF WAGES CERTIFICATE – FOR COMPLETION BY CLAIMANT’S EMPLOYER**

**COMPANY NAME**

**PHONE NUMBER**

**EMAIL ADDRESS**

**POSTAL ADDRESS**

**EMPLOYEE’S NAME**  **EMPLOYEE’S PPS NUMBER**  **EMPLOYEE’S PPS CLASS**

**DATE EMPLOYMENT COMMENCED**  **DATE LAST WORKED**  **DATE OF NOTIFICATION OF LOSS OF WAGES**

**REASON FOR LOSS OF WAGES**  **DATE RETURNED TO WORK**

**Amount of Loss of Basic Net Weekly Wages (Excluding overtime, allowances etc.)** €

Please attach 3 recent payslips or a letter from your Employer stating your net weekly wage.

**Is the above employee contributing to company Health Insurance scheme** Yes  No

**I hereby certify that the employee is at a loss of net weekly wages and was in Permanent employment of at least 16 hours on average per week prior to the loss and no sick pay scheme is in operation.**

**Personnel Officer / Manager’s Name (BLOCK CAPITALS)**

**Personnel Officer / Manager’s Signature**

**Date**

**Employers Stamp**

(If no stamp available, please attach a letter on company headed paper confirming the above details)



**SECTION E – SOCIAL WELFARE BENEFIT – FOR COMPLETION BY SOCIAL WELFARE OFFICE**

**NAME**

**PPS NUMBER**

I certify that the above name has been in receipt of Illness Benefit for the period

to

at a rate of €

per week.

I certify that the above name is NOT entitled to Illness Benefit for the period

to

**Official's Name (BLOCK CAPITALS)**

**Official's Signature**

**Date**

**Official Stamp**



**SECTION F – MEDICAL CERTIFICATE – FOR COMPLETION IN ALL CASES BY THE MEDICAL PRACTITIONER WHO ATTENDED THE CLAIMANT**

**PATIENT'S NAME**

**DATE OF BIRTH**

**PATIENTS ADDRESS**

**CAUSE OF DISABILITY AND DETAILS OF TREATMENT ADMINISTERED:**

**DATE OF DIAGNOSIS**

**IS THE INJURY CAMOGIE RELATED?**

**DATE OF FIRST CONSULT FOR INJURY**

**Date from when unfit for work**

**Date when fit to return to work  
(If unknown, please estimate)**

Has the Claimant received Physiotherapy for this injury?

Yes

No

Was the Claimant referred for Physio by you? (Please include referral letter)

Yes

No

**Doctor / Dentist / Physiotherapist's Declaration**

I declare that to the best of my knowledge, the above information is accurate and correct and that the disability has been continuous as stated above.

**Official's Name (BLOCK CAPITALS)**

**Official's Signature**

**Date**

**Official Stamp**

(If no stamp is available, please attach a letter  
On headed paper confirming the above details)

**Telephone Number**



**SECTION G – DECLARATION – TO BE COMPLETED IN ALL CASES BY THE CLAIMANT,  
CLUB SECRETARY AND CLUB CHAIRPERSON**

**Claimant's Declaration**

I hereby declare that to the best of my knowledge the foregoing statements are true in every respect.

I hereby authorise the doctor / dentist / physiotherapist / hospital / employer / Private Health Insurer / Dept. of Social Protection (or equivalent) to supply any information requested. I understand that any deliberate misstatement will void the claim in its entirety.

I consent for the purposes of the Data protection Acts, 1988 and 2003 to the information I give on this form and any other form issued to me in connection with this claim and to any other information that I give in relation to this claim being held and assessed by Aviva.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Aviva in assessment of this claim.

**To whom should the Settlement be made payable to**

**Relationship to the Claimant**

**Claimants Name (BLOCK CAPITALS)**

**Claimant's Signature**

**Date**

**Club Secretary's Declaration**

I declare that the above named claimant was injured as a result of participating in an officially sanctioned game or training session.

**Secretary's Name (BLOCK CAPITALS)**

**Secretary's Signature**

**Date**

**Passed By the Club Chairperson**

I declare that the above named claimant was injured as a result of participating in an officially sanctioned game or training session.

**Chairperson's Name (BLOCK CAPITALS)**

**Chairperson's Signature**

**Date**



## Sections of Claim Form to be Completed and Required Documents:

### Claim Type A – Dental / Medical / Physiotherapy Claims

1. Section A – Claimant Details
2. Section B – Injury Details
3. Section F – Medical Certificate
4. Section G – Declaration
5. **Note for Physio Expenses Claims:** A referral letter from a Medical practitioner is required

#### Documents Required:

1. Claim Form
2. Receipts for Medical Treatments received
3. Details of any Private Health Insurance Cover applicable to this claim
4. Referee Report from Match where injury occurred. If injury occurred during training, letter of confirmation from club secretary required

### Claim Type B – Loss of Wages (Temporary Total Disablement) – Employed Person

1. Section A – Claimant Details
2. Section B – Injury Details
3. Section D – Loss of Wages Certificate
4. Section E – Social Welfare Declaration
5. Section F – Medical Certificate
6. Section G – Declaration

#### Documents Required:

1. Claim Form
2. Receipts for Medical Treatments received
3. Letter from Employer to confirm dates not worked
4. Copies of Previous 3 Months Wage Slips
5. Copies of Social Welfare Benefit received or Confirmation of non-entitlement to cover
6. Details of any Private Health Insurance Cover applicable to this claim
7. Referee Report from Match where injury occurred. If injury occurred during training, letter of confirmation from club secretary required

### Claim Type C – Loss of Wages (Temporary Total Disablement) – Self-Employed Person

1. Section A – Claimant Details
2. Section B – Injury Details
3. Section C – Loss of Wages Certificate
4. Section E – Social Welfare Declaration
5. Section F – Medical Certificate
6. Section G – Declaration

#### Documents Required:

1. Claim Form
2. Receipts for Medical Treatments received
3. Letter from Accountant to Confirm Loss of Earnings
4. Copies of Social Welfare Benefit received or Confirmation of non-entitlement to cover
5. Details of any Private Health Insurance Cover applicable to this claim
6. Referee Report from Match where injury occurred. If injury occurred during training, letter of confirmation from club secretary required