AVIVA

GOGANS SPORTS PERSONAL ACCIDENT INSURANCE SCHEME

SECTION A – CLAIMANT & CLUB DETAILS

DATE OF INJURY

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

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.

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SECTION A CONTINUED

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 ☐

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 104 weeks **excluding** the first two 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 2	Nil
Weeks 3 to 104	up to €500.00

The above is purely a summary of benefits payable for assistance when completing this claim form ALL BENEFITS WILL BE HALVED IN THE EVENT THAT PROTECTIVE HEAD GEAR IN NOT WORN

SECTION B – INJURY DETAILS

AMOUNT BEING CLAIMED

EXACT NATURE & CIRCUMSTANCE OF INJURY

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:

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	

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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 _____

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

PATIENT'S NAME | **DATE OF BIRTH**

PATIENTS ADDRESS

CAUSE OF DISABILITY AND DETAILS OF TREATMENT ADMINISTERED:

DATE OF DIAGNOSIS

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** ☐

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 CHAIPERSON

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 Date 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.

Club Chairperson's Name (BLOCK CAPITALS)	
Club 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

Documents Required:

1. Claim Form
2. Receipts for Medical Treatments received
3. Details of any Private Health Insurance Cover applicable to this claim

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

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