DECLARATION

Web Reference

Claimant's Declaration

I declare that to the best of my knowledge, the foregoing statements are true in every respect. I hereby authorise the doctor / dentist / hospital / employer / VHI / Laya Health Care / Irish Life Health / Department of Employment Affairs and Social Protection / Department of Communities 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 claim 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 Willis Towers Watson and the GAA.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Willis Towers Watson and /or GAA in assessment of this claim.

Name (block capitals)

Signature

Date / /

Club Secretary \ Injury Fund Administrator Declaration

I declare that the above named claimant was injured as a result of participating in an Official Fixture as recorded in the attached Referees report. Yes No

I declare that the above named claimant was injured as a result of participating in an Official Supervised Training Session \ or an Official Sanctioned Challenge Match (delete as applicable), letter attached from Club Secretary \ Injury Fund Administrator on official club headed paper confirming same. Yes No

Claimant's Membership Number

Name (block capitals)

Signature

Date / /

Passed by County Secretary

I declare that the above named claimant was injured as a result of participating in an Official Fixture as recorded in the attached Referees report. Yes No

I declare that the above named claimant was injured as a result of participating in an Official Supervised Training Session \ or an Official Sanctioned Challenge Match (delete as applicable), letter attached from Club Secretary \ Injury Fund Administrator on official club headed paper confirming same Yes No

Name (block capitals)

Signature

Date / /

MEDICAL CERTIFICATION – FOR COMPLETION IN ALL CASES BY THE DOCTOR/DENTIS ONLY WHO ATTENDED THE CLAIMANT.

Cost of completion of the Medical Section of this claim form must be borne by the claimant

Web Reference [ ]

Patient's Name [ ]

Patient's Date of Birth [ ]

Address [ ]

[ ]

Please state specific diagnosis [ ]

Cause of disability and details of treatment administered / prescribed [ ]

Date of diagnosis [/ /]

Date patient first consulted you for this disability [/ /]

Date from which unfit for work [/ /]

Date fit to return to work (if known) If unknown, please give estimate [/ /]

Has the claimant ever had this or a similar disability/treatment before? Yes [ ] No [ ]
If Yes, please give date and detail

[ ]

[ ]

Please Indicate if this injury is GAA related Yes [ ] No [ ]

Please indicate if the claimant has suffered an accidental bodily injury Yes [ ] No [ ]

Doctor's/Dentist'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.

Name (block capitals) [ ]

Signature [ ]

Telephone Number [ ]

Date [/ /]

Stamp
(if no stamp available a business card or confirmation on the qualified practitioners headed paper must be submitted)

[ ]