GAA Injury Scheme
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GAA INJURY CLAIM FORM

To be submitted to Coyle Hamilton Willis within 60 days of injury

HOW TO COMPLETE THIS FORM

MEDICAL EXPENSES > SECTIONS A, E, F
LOSS OF WAGES (EMPLOYED) > SECTIONS A, C, D, E, F
LOSS OF WAGES (SELF EMPLOYED) > SECTIONS A, B, D, E, F

Claim No. _____

Section A. TO BE COMPLETED IN ALL CASES. PLEASE USE BLOCK LETTERS

Claimant/Injured Person

Name of Club/County (or School/College etc.)

Full Address of Claimant

Full Address of Club

Date of Birth

Type of Team (e.g. Football, Hurling, Handball or Rounders)

Contact Number

Grade of Team (e.g. Senior, U18 etc.)

Occupation (if applicable)

Team ☐ A ☐ B ☐ C

Employment Status (tick as appropriate) Student ☐ Employed ☐ Self Employed ☐ Unemployed ☐

Medical Insurance details

VHI? Yes ☐ No ☐ Other Insurance? Yes ☐ No ☐

Quinn Health Care? Yes ☐ No ☐ VIVAS? Yes ☐ No ☐

The Injury Scheme only provides cover for non-recoverable costs up to the limit of the scheme. Therefore please provide a statement of account from your Medical Insurance Provider.

Failure to complete this form may result in delays in your claim

Section A. CONTINUED TO BE COMPLETED IN ALL CASES. PLEASE USE BLOCK LETTERS

Nature of Possible Claim (tick as appropriate)

Loss of Wages

☐

– Applicable to Adults/Youths who are in full time employment ('employment' means – permanent gainful employment of not less than 16 hours per week)
– Benefit is payable for full weeks only up to a maximum of 52 weeks **excluding** the first week.
– The maximum benefit payable is as follows –
Week 1 – €Nil.
Weeks 2 to 4 – Up to €200.
Weeks 5 to 52 – Up to €400.

– The Injury Scheme only provides cover for non-recoverable costs of nett basic wage (excluding overtime, bonuses, unsociable working hours, allowances etc). Social Welfare and/or other entitlements will be considered as recoverable income and will be deducted from the basic nett wage figure.

Medical Expenses

☐

– Non-recoverable medical expenses up to a limit of €5000, **excluding** the first €60 of each and every claim. Medical Treatment is only covered if provided by recognised/qualified practitioners.
– Please note that, Physiotherapy, Osteopathy, Chiropractic, Sports Massage, Acupuncture etc, must be medically prescribed and are limited to €200 in total per claim. However medically prescribed post operative treatment is exempt from the limit of €200.

Dental Expenses

☐

Non-recoverable dental expenses up to a limit of €5000, **excluding** the first €60 of each and every claim

Supplementary Hospital Benefit

☐

Benefit payable – €400 per days stay in hospital. Benefit only payable if stay is a minimum of 10 consecutive days up to a maximum of 15 days.

Permanent Disability

☐

Lifetime Disability Benefit – €300,000 (A single identifiable occurrence on the field of play resulting in permanent total physical paralysis such that the Insured Person is confined to a wheelchair for life)

Capital Benefits

Permanent Total Disablement from gainful employment Up to – €100000
Loss of eye(s) or limb(s), or loss of hand(s) or foot/feet Up to – €100000
Complete and incurable paralysis Up to – €100000
Permanent Partial Disablement – 'Continental Scale to a maximum of €50000

Death Benefit

Adult or Married Youth – €50000
Youth – €25000

The above is purely a summary of benefits payable for assistance when completing this claim form.

Date of Injury / /

Opposition

Nature of Injury

Brief Details of Circumstances

Section B. LOSS OF WAGES CERTIFICATION - FOR COMPLETION BY SELF EMPLOYED CLAIMANT

Name of Company

Address

Business Description

Nature of Employment (e.g. farmer, sole trader, partnership)

Amount of average nett weekly income €

Weekly nett wage paid to substitute worker(s) (if any) €

Reason for loss of income

I declare that I am unfit for work following injury as a result of participating in Gaelic Football, Hurling, Handball or Rounders and unable to earn my average nett weekly income.

I attach

(i) Confirmation of my loss of nett weekly wages from my Accountant (include Chartered Accountants Registration No.)

(ii) Details of my claim with the Department of Social, Community and Family Affairs or the Social Security Agency.

Signed Date

Section C. LOSS OF WAGES CERTIFICATION - FOR COMPLETION BY CLAIMANT'S EMPLOYER

Employer's Name

Phone Number

Company Registration Number

Address

Section C. CONTINUED LOSS OF WAGES CERTIFICATION - FOR COMPLETION BY CLAIMANT'S EMPLOYER

Employee's Name

Employee's RSI No

Employee's RSI Class

Date employment commenced / /

Date last worked / /

Date of notification of loss of wages / /

Reason for loss of wages

Date returned to work / /

(excluding overtime, allowances etc.)

Amount of loss of Basic Nett weekly wages **€**

(Please attach 3 recent payslips dated prior to the injury, or a letter from employer stating your nett weekly wage)

Is the above employee contributing to a company VHI or equivalent scheme? Yes ☐ No ☐

I hereby certify that the employee is at a loss of nett 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's/Manager's Name (block capitals)

Personnel Officer's/Manager's Signature

Date / /

Employers Stamp

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

Section D. (i) SOCIAL WELFARE BENEFIT - FOR COMPLETION BY SOCIAL WELFARE OFFICE (ii) STATUTORY SICK PAY CERTIFICATION (FOR RESIDENTS OF NORTHERN IRELAND ONLY) - FOR COMPLETION BY CLAIMANT'S EMPLOYER

I certify that the above named has been in receipt of Illness Benefit for the period / / to / /

at a rate of € per week

I certify that the above named is not entitled to Illness Benefit for the period / / to / /

as (please state reason)

Official's Name (block capitals)

Official's Signature

Date / /

Official Stamp

Section E. MEDICAL CERTIFICATION - FOR COMPLETION IN ALL CASES BY THE DOCTOR/DENTIST WHO ATTENDED THE CLAIMANT

Patient's Name

Patient's Date of Birth

Patient's Address

Please state specific diagnosis

Cause of disability and details of treatment administered

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 details.

Please Indicate if this injury is GAA related 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 No

Date / /

Stamp

Section F. TO BE COMPLETED IN ALL CASES BY CLAIMANT, CLUB SECRETARY AND COUNTY SECRETARY

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 / physiotherapist / hospital / employer / VHI / Quinn Health Care / VIVAS / Dept. of Social Welfare to supply any information requested. I understand that any deliberate misstatement will void the claim in it's 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 Coyle Hamilton Willis and the GAA.

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

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 Yes ☐ No ☐

I declare that the above named claimant was injured as a result of participating in an officially sanctioned Training Session Yes ☐ No ☐

Name (block capitals)

Signature

Date / /

Passed by County Secretary

I declare that this was an officially sanctioned Game Yes ☐ No ☐

I declare that this was an officially sanctioned Training Session Yes ☐ No ☐

Name (block capitals)

Signature

Date / /

Please forward this completed form to Coyle Hamilton Willis Ltd., Grand Mill Quay, Barrow St,Dublin 4, within 60 days of the date of injury.