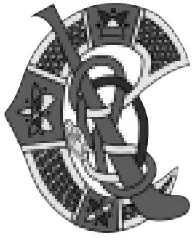

Camógie Player Injury Insurance Scheme
Coyle Hamilton Willis Limited are the appointed Administrators
Tel: 01 669 4446 Fax 01: 661 4369 Email: gaa.queries@coylehamiltonwillis.ie

CAMÓGIE PLAYERS INJURY INSURANCE SCHEME

CLAIM FORM

Claim No. ______________________

To be submitted to Coyle Hamilton Willis within 30 days of injury (within 60 days where Preliminary Notification form has been submitted)

HOW TO COMPLETE THIS FORM

DENTAL / MEDICAL EXPENSES - SECTIONS A, B, F and G
LOSS OF WAGES (EMPLOYED) - SECTIONS A, B, D, E AND G
LOSS OF WAGES (SELF EMPLOYED) - SECTIONS A, B, C, E AND G

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

Claimant/Injured Person

Name of Club

Full Address of Claimant

Full Address of Club

Date of Birth

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

Contact Number

Match official / trainer (please specify)

Employment Status (tick as appropriate)

Student ☐ Employed ☐ Self Employed ☐ Unemployed ☐

Occupation (if applicable)

Medical Insurance (Medical Card No.)

VHI? Yes ☐ No ☐

Other Insurance? Yes ☐ No ☐

NHS? Yes ☐ No ☐

BUPA? Yes ☐ No ☐

Nature of Possible Claim (tick as appropriate)

Loss of Wages ☐
(subject to policy excess of 2 weeks)

Medical Expenses ☐
(subject to policy excess of €75)

Dental Expenses ☐
(subject to policy excess of €75)

Permanent Disability ☐

Physiotherapy ☐
(subject to 90% cost of physiotherapy up to €400 max)

Section B. TO BE COMPLETED IN ALL CASES

Date of Injury

Nature of Injury

Where did the injury occur? Camógie training ☐ Challenge match ☐

Official match ☐ Other (please specify)

Were you wearing protective headgear at the time? Yes ☐ No ☐

Brief Details of Circumstances

Where a claim is agreed, payment may be made to your bank account. Please supply details.

Bank Name and Address

Bank Sort Code

Account No:

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

Name of Company

Address

Business Description

Nature of Employment

Amount of average weekly net income €

Weekly net 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 a camógie match/training and unable to earn my average weekly income.

I attach

(i) Confirmation of my loss of net weekly wages from my Accountant

(ii) Tax Return for the past year

(iii) Evidence of last 3 months earnings

Signed Date

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

Employer's Name

Phone Number

Company Registration Number

Address

Employee's Name

Employee's RSI No

Employee's RSI Class

Date employment commenced / /

Date of notification of loss of wages / /

Reason for loss of wages

Date returned to work / /

Amount of loss of Basic Nett weekly wages € (excluding overtime,allowances etc.)

(Please attach 3 recent payslips or a letter from employer stating your nett weekly wage)

I hereby certify that the employee is at a loss of 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.
I also confirm that the above employee is not contributing to a Company VHI (or equivalent) Scheme.

Personnel Officer's/Manager's Signature

Date / /

Employer's brand

Section E. (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 (a) in receipt of or (b) is not entitled to (delete as applicable) Disability Benefit for

the period / / to / / at a rate of € per week

Official Signature

Date / /

Official Stamp

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

Name of Doctor or Dentist

Phone No.

Address

When was it made known to you that this particular disability (which is the subject of a claim) occurred?

Nature / cause of disability and details of treatment administered

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? Please give date and details.

Has the claimant received physiotherapy treatment for this injury. Yes ☐ No ☐

If yes, have they resumed playing / training with the Camógie Club during their Physiotherapy treatment

Yes ☐ No ☐

On the basis of your existing knowledge and without undertaking any further examination, is it your opinion that the disablement indicated above is solely attributable to the specified injury sustained? If not, please state below any contributing factors and the extent to which disablement is or has been thereby affected

Doctor's / Dentist's Declaration

Stamp

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.

Signature

Date / /

Section G. 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 / consultant / hospital / employer / other Insurer / Department of Social, Community and Family Affairs to supply any information you may request.
I understand that any deliberate misstatement will void the claim in it's entirety.

Signature

Date / /

Club Secretary's Declaration

I declare that the above named claimant was injured as a result of participating in an organised (delete as applicable) Camógie Official Match/Training Session. A copy of the Referee's Report is attached / Letter from the Club Secretary is attached confirming that the incident occurred in an official training session.

Signature

Date / /

Passed by County Secretary

Signature

Date / /

Please forward this completed form to Coyle Hamilton Willis Ltd., 7/9 South Leinster Street, Dublin 2, within 30 days of the date of injury (within 60 days where Preliminary Notification form has already been submitted)