Claim No. ____________________

GAA Player Injury Scheme
Managed by Coyle Hamilton Limited, 7/9 South Leinster Street, Dublin 2
Tel: 01 6396343 Fax 01: 6614369
Email: gaa.queries@coylehamilton.com
www.coylehamilton.com/gaa

GAA PLAYERS INJURY CLAIM FORM

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

HOW TO COMPLETE THIS FORM

MEDICAL EXPENSES - SECTIONS A AND E

LOSS OF WAGES (EMPLOYED) - SECTIONS A, C, D AND E

LOSS OF WAGES (SELF EMPLOYED) - SECTIONS A, B, AND E

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

Claimant/Injured Person ______

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

Full Address of Claimant ______

Full Address of Club ______

Date of Birth ______

Type of Team (e.g. football, Hurling etc.) ______

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 (Medical Card No.) ______

VHI? Yes ☐ No ☐

Other Insurance? Yes ☐ No ☐

NHS? Yes ☐ No ☐

Voluntary Insurance? Yes ☐ No ☐

Nature of Possible Claim (tick as appropriate)

Loss of Wages (subject to policy excess of 1 week) ☐

Permanent Disability ☐

Medical Expenses (subject to policy excess of €60) ☐

Hospitalisation (only where period of hospitalisation exceeds 10 days) ☐

Dental Expenses (subject to policy excess of €60) ☐

☐

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

	yes	no
Farmer		
Do you own farm		
Sole Trader		
Partnership		
How many partners		

Amount of average weekly income €

Weekly 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 and unable to earn my average weekly income.

I attach

(i) Confirmation of my loss of wages from my Accountant/Bank

(ii) Tax Return for the past year

(iii) Evidence of last 3 months earnings

Signed

Date

/ /

Section E. 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.

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.

Stamp

Signature

Date / /

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 / hospital / employer / VHI / Dept. of Social Welfare to supply any information requested. I understand that any deliberate misstatement will void the claim in it's entirety.

Signature

Date

Club Secretary's Declaration

Is this Club registered with the GAA Player Injury Scheme for the year of injury? Yes ☐ No ☐

I declare that the above named claimant was injured as a result of participating in an organised (delete as applicable) (i) Gaelic Football/Hurling ***and*** (ii) 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 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)

Section C. 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 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 (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