



GAA Player Injury Scheme
Managed by Coyle Hamilton Willis Ltd, 7-9 South Leinster Street, Dublin 2
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GAA PLAYERS INJURY CLAIM FORM

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

Claim No. _____

HOW TO COMPLETE THIS FORM

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

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

Claimant/Injured Person

Name of Club (or School/College/County 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
(Medical Card No.)

VHI? Yes No

Other Insurance? Yes No

NHS? Yes No

Voluntary Insurance? Yes No

Please forward a Statement of Account of your Medical Insurance Claim.

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 (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/Bank (include Chartered Accountants Registration No.)**
- (ii) **Tax Return for the past year**
- (iii) **Evidence of last 3 months earnings**
- (iv) **Details of my claim with the Department of Social, Community and Family Affairs or the Social Security Agency.**

Signed

Date

Section C.**DATA PROTECTION ACT -
FOR COMPLETION SHOULD YOU WISH TO AUTHORISE A THIRD PARTY
TO BE PROVIDED WITH INFORMATION REGARDING YOUR CLAIM**

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 for the purpose of assessing the claim.

I give my authorisation for the following person(s) (if any) to be provided with information regarding my claim.

Name

Please state this person's relationship to you e.g. father, mother, solicitor etc.

Name

Please state this person's relationship to you e.g. father, mother, solicitor etc.

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 last worked

 / /

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)**

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

 / /

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

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 in receipt of Disability Benefit for the period / / to / / at a rate of € per week

I certify that the above named is not entitled to Disability Benefit for the period / / to / / as (please state reason)

Official's Name (block capitals)

Official Stamp

Official's Signature

Date

 / /

Section F.**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.

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

Stamp

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 / physiotherapist / hospital / employer / VHI / BUPA / VIVAS / Dept. of Social Welfare to supply any information requested. I understand that any deliberate misstatement will void the claim in its 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 officially sanctioned Game/Training Session (delete as applicable)..

Name (block capitals)

Signature

Date

Passed by County Secretary

I declare that this was an officially sanctioned Game/Training Session

Name (block capitals)

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)