



GAA Player Injury Scheme

Managed by Coyle Hamilton Limited, 7/9 South Leinster Street, Dublin 2

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GAA PLAYERS INJURY CLAIM FORM

Claim No. _____

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

Full Address of Claimant

Date of Birth

Contact Number

Occupation (if applicable)

Employment Status (tick as appropriate)

Student

Employed

Name of Club (or School/College etc.)

Full Address of Club

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

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

Team

A

B

C

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	<input type="checkbox"/>	<input type="checkbox"/>
Do you own farm	<input type="checkbox"/>	<input type="checkbox"/>
Sole Trader	<input type="checkbox"/>	<input type="checkbox"/>
Partnership	<input type="checkbox"/>	<input type="checkbox"/>
How many partners	<input type="text"/>	

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.

Signature

Stamp

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 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 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