GAA Injury Scheme
Administered by Willis, Grand Mill Quay, Barrow St, Dublin 4.
Tel: 01 6396343 Fax: 01 6694443
Email: gaa.queries@willis.ie

GAA INJURY CLAIM FORM

AS A MINIMUM THE FIRST TWO PAGES MUST BE SUBMITTED TO WILLIS WITHIN 60 DAYS OF INJURY. CLAIMS REPORTED OUTSIDE THE 60 DAYS WILL NOT BE PROCESSED.

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.)

Hurling Injuries Only (tick as appropriate)

Were you wearing an approved helmet? Yes ☐ No ☐

Please specify which helmet Mycro ☐ Marc ☐ Azzurri ☐

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 Healthcare? Yes ☐ No ☐ Aviva? Yes ☐ No ☐

Please specify full name of your Medical Insurance Cover Plan

The Injury Scheme only provides cover for non-recoverable costs up to the limit specified under the scheme. If you have medical insurance, a claim must be made with your Medical Provider. Therefore you must supply a statement of account or letter confirming you are not covered for your medical costs from your Medical Provider.
Failure to supply same will delay the assessment of your claim

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

Nature of Possible Claim (tick as appropriate)

Loss of Wages

☐

- Applicable to Adults/Youths who are in full time employment at date of injury ('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/Income Protection and/or other entitlements will be considered as recoverable income and will be deducted from the basic nett wage figure.

Medical Expenses

☐

- If you have medical insurance e.g. VHI, Quinn Healthcare, a claim must be made with your medical provider. Otherwise unrecoverable medical expenses are covered up to a maximum of €4,500 (This benefit includes cover for MRI Scans up to a limit of €300 per scan and Post Operative treatment up to a limit of €320. A maximum benefit of €40 per any one treatment applies)

- The first €100 of each and every claim is excluded.

Dental Expenses

☐

Non-recoverable dental expenses up to a limit of €4,500, **excluding** the first €100 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)

(i) Capital Benefits
*Permanent Total Disablement – €100,000
*Loss of sight – €100,000
*Permanent Partial Loss of Sight – Up to €100,000
*Loss of Limb(s) – €100,000
*Complete and incurable paralysis – €100,000
*All above benefits Less any Loss of Wages Benefit claimed.

Permanent Partial Disablement
A scale of benefits providing for benefits to a maximum of €50,000 for specified disabilities applies. Details available on request.

(ii) Death Benefit
Adult (or Married Youth) – €50,000
Youth – €25,000

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

Injury Occurred during (tick as appropriate)

Official Match ☐ Official Training Session ☐ Challenge Match ☐

Claimants Signature Date / /

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 and Family Affairs or the Social Security Agency.

(iii) Details (if applicable) of any benefit received from my Income Protection policy.

Signed

Date

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

Continued overfleaf

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 / /

Section C. Continued — LOSS OF WAGES CERTIFICATION – FOR COMPLETION BY CLAIMANT'S EMPLOYER

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 D. (i) SOCIAL WELFARE BENEFIT – FOR COMPLETION BY SOCIAL WELFARE OFFICE

(A claim must be made with your local 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 **ONLY** WHO ATTENDED THE CLAIMANT.

Cost of completion of the Medical Section of this claim form must be borne by 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/prescribed

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? If Yes, please give date and detail Yes ☐ No ☐

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

Stamp

(if no stamp available a business card or confirmation on the qualified practitioners headed paper must be submitted)

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/ Quinn Health Care/Aviva/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 Willis and the GAA.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by 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 Official Match as recorded in the attached Referees Report. Yes ☐ No ☐

I declare that the above named claimant was injured as a result of participating in an Official Training Session/Challenge Match (delete as applicable) Letter attached from Club Chairman/Secretary confirming same. Yes ☐ No ☐

I declare that the above named claimant was injured in accordance with Clause 1.4. Letter attached from Club Chairman/Secretary confirming the claimant's membership and stating the circumstances surrounding the accident/injury. Yes ☐ No ☐

Claimant's Membership Number

Name (block capitals)

Signature

Date / /

Passed by County Secretary

I declare that the above named claimant was injured as a result of participating in an Official Match as recorded in the attached Referees Report. Yes ☐ No ☐

I declare that the above named claimant was injured as a result of participating in an Official Training Session/Challenge Match (delete as applicable) Letter attached from Club Chairman/Secretary confirming same. Yes ☐ No ☐

I declare that the above named claimant was injured in accordance with Clause 1.4. Letter attached from Club Chairman/Secretary confirming the claimant's membership and stating the circumstances surrounding the accident/injury. Yes ☐ No ☐

Name (block capitals)

Signature

Date / /

(Please forward this completed form to Willis, Grand Mill Quay, Barrow Street, Dublin 4, within 60 days of the date of injury)