

Nature of Possible Claim (tick as appropriate)

Loss of Wages (Temporary Total Disablement)

- Applicable to all Insured Persons over 18 years who are in full time employment working a minimum of 16 hours per week and is only payable if you are unable to work due to injury received in the course of playing/training Camogie.
- This Benefit shall pay for otherwise unrecoverable loss of basic nett wage excluding overtime, bonuses and unsociable working hours and shall be payable for 28 weeks **excluding** the first two weeks.
- Social Welfare shall be considered as recoverable income and will be deducted from the basic nett wage figure.
- Benefit is payable for each complete week (7 consecutive days) and no Benefit shall be payable for partial weeks.
- The maximum benefit payable is as follows
Weeks 1 to 2—€Nil.
Weeks 3 to 28 —up to €500
- Special Condition Applying to Benefit 6 Loss of Wages (Temporary Total Disablement)

In respect of all Insured Persons over 18 years who are not in full time employment Benefit 6 shall be reduced to €200 for each complete week the insured person is unable to carry out normal domestic duties as confirmed by a doctor's certificate.

Medical /Physiotherapy Expenses

- Non recoverable medical expenses up to a limit of €5000 **excluding** the first €75 for each and every claim
- Physiotherapy only claims where there is no other medical expense is subject to an **excess of 10%** of the cost of the prescribed treatment.

Dental Expenses

Non-recoverable dental expenses up to a limit of €5000, excluding the first €75 for each and every claim

Permanent Disability

- Death €100,000 Adult,
€20,000 Youth (under 18 years)
- Lifetime Total Disability €100,000
- Loss of Two or more limbs or both eyes or one of each €100,000
- Loss of one limb or eye €100,000
- Permanent Specific Disablement (As defined in the Policy Document) €100,000 (or according to the Scale of Benefits)

**The above is purely a summary of benefits payable for assistance when completing this claim form.
ALL BENEFITS WILL BE HALVED IN THE EVENT THAT PROTECTIVE HEAD GEAR IS NOT WORN.**

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

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

I attach

- (i) Confirmation of my loss of nett weekly wages from my Accountant (include Chartered Accountants Registration No)
- (i) Details of my claim with the Department of Social, Community and Family Affairs.

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 PPS No

Employee's PPS 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

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

Official Stamp

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.

Please Indicate if this injury is Camogie 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

Date

 / / **Stamp****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 / Hibernian Health / Quinn Health Care / 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 Coyle Hamilton Willis.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Coyle Hamilton Willis in assessment of this claim.

Signature

Date

Club Secretary's DeclarationI declare that the above named claimant was injured as a result of participating in an officially sanctioned Camogie Game Yes No I declare that the above named claimant was injured as a result of participating in an officially sanctioned Training Session Yes No

Name (block capitals)

Signature

Date

Passed by County SecretaryI declare that this was an officially sanctioned Camogie Game Yes No I declare that this was an officially sanctioned Camogie Training Session Yes No

Name (block capitals)

Signature

Date

 / / **Please forward this completed form to Coyle Hamilton Willis Ltd., Grand Mill Quay, Barrow St, Dublin 4, within 30 days of the date of injury.**