Camógie Personal Accident Insurance Scheme
Administered by Willis Towers Watson, Elm Park, Merrion Road, Dublin 4
Tel: 01 6396343, Fax: 01 6694443
Email: gaa.queries@willistowerswatson.com

CAMOGIE PERSONAL ACCIDENT INSURANCE SCHEME

CLAIM FORM

Claim No. _____

As a minimum the first two pages must be submitted to Willis Towers Watson within 30 days of the injury.

HOW TO COMPLETE THIS FORM

DENTAL/MEDICAL EXPENSES – SECTIONS A, B, F and G
LOSS OF WAGES (TEMPORARY TOTAL DISABLEMENT) EMPLOYED – SECTIONS A, B, D, E, F AND G
LOSS OF WAGES (TEMPORARY TOTAL DESABLEMENT) SELF EMPLOYED – SECTIONS A, B, C, E, F AND G

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

Claimant/Injured Person

Name of Club

Full Address of Claimant

Full Address of Club

Date of Birth

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

Contact Number

Match official/trainer (please specify)

Contact Email Address

Employment Status (tick as appropriate)

Student ☐ Employed ☐ Self Employed ☐ Not in Employment ☐

Occupation (if applicable)

Medical Insurance Details

VHI? Yes ☐ No ☐ Other Insurance? Yes ☐ No ☐

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

Please specify full name of your Medical Insurance Cover Plan

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The Camogie Personal Accident Insurance 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. CONTINUED TO BE COMPLETED IN ALL CASES. PLEASE USE BLOCK LETTERS

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 104 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 104 – up to €500

Medical/Physiotherapy Expenses

☐

- Non-recoverable medical expenses up to a limit of €10,000 **excluding** the first €75.00 (adult member)\€50.00 (youth member).
- Physiotherapy only claims where there is no other medical expense is subject to an **excess of 10%** of the cost of the prescribed treatment or a minimum of €75.00 per Adult\Youth Member claim.

Dental Expenses

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- Non-recoverable dental expenses up to a limit of €10,000 excluding the first €75.00 (adult member)\€50.00 (youth member).

Hospital Confinement

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- €20.00 per complete day (24 hour period) up to a maxium of 90 days from the day of 1st confinement.

Permanent Disability

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– Death	€125,000 Adult, €40,000 Youth (under 18 years)
– Permanent total loss of sight in one eye or loss\loss of use of one limb	€125,000
– Permanent total loss of sight in both eyes or loss\loss of use of both limbs	€125,000
– Permanent total disability	€125,000

The above is purely a summary of benefits payable for assistance when completing this claim form.

SECTION B. TO BE COMPLETED IN ALL CASES

Date of Injury ☐☐ / ☐☐ / ☐☐☐☐

Nature of Injury ☐

Where did the injury occur? Camogie 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 camogie match/training and unable to earn my average weekly income.

I attach

(i) Confirmation of my loss of net weekly wages from my Accountant (include Chartered Accountants Registration No)

(ii) 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/PHYSIOTHERAPIST 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 received physiotherapy treatment for this injury. Yes ☐ No ☐

If Yes, please give date and details.

Please Indicate if this injury is Camogie related Yes ☐ No ☐

Doctor's/Dentist's/Physiotherapist 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
(If no stamp available please attach a letter on headed paper confirming the above details)

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/Aviva/Laya Healthcare/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 Towers Watson.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Willis Towers Watson 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 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 Secretary

I 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 / /