**Hockey Wales**

Personal Accident Claim Form

Once completed this form should be sent to Watkin Davies Insurance Consultants

This form should be completed by the Claimant if over 18

If under 18 the form must be completed by a parent / guardian

PLEASE NOTE THAT TO ENABLE THE INSURER TO CONSIDER ANY CLAIM FOR THE COST OF MEDICAL EXPENSES FOLLOWING AN ACCIDENT, EVERY TREATMENT INVOICE MUST CONFIRM THE AREA OF THE BODY TREATED.

ANY INVOICE(S) WHERE THE BODY PART IS NOT CONFIRMED WILL BE RETURNED TO YOU, UNPAID, FOR AMENDMENT BY THE TREATING PRACTITIONER

THE CONFIRMATION OF THE AREA OF TREATMENT CAN BE ONE OF THE FOLLOWING:

1. ELECTRONIC INVOICE(S) CONFIRMING BODY PART TREATED
2. HANDWRITTEN ENDORSEMENT ON EACH INVOICE, SIGNED AND DATED BY THE TREATING

PRACTITIONER

1. A LETTER, ON PRACTICE HEADED PAPER, CONFIRMING THE DETAILS OF THE RELEVANT

INVOICE(S) AND TREATMENT PROVIDED

PLEASE NOTE THAT CONFIRMATION OF THE BODY PART ON THE MEDICAL CERTIFICATE IS NOT SUFFICIENT FOR INSURERS PURPOSES.

SECTIONS 1-6 MUST BE FULLY COMPLETED IN ALL CASES

REMAINING SECTIONS REQUIRE COMPLETION AS INDICATED BELOW

Please confirm under which section of the Personal Accident Policy you wish to claim:

|  |  |
| --- | --- |
| Death/Funeral Expenses  | YES / NO   |
| Capital Benefits (Permanent Disablement)  | YES / NO   |
| Dental treatment following injury  | YES / NO   |
| Medical Expenses e.g. Physiotherapy, Radiotherapy, Manipulative Massage, Soft Tissue Treatment Complete Sections 7 & 8 and Provide Completed medical Certificate  | YES / NO  |
| Hospital benefit Complete Section 9, Doctor to Complete Hospitalisation Certificate or Provide Hospital Discharge Paperwork  | YES / NO  |
| Travel/Accommodation expenses of relatives Complete Section 10, Doctor to Complete Hospitalisation Certificate or Provide Hospital Discharge Paperwork  | YES / NO  |
| Loss of Earnings as a Coach Complete Section 11 and Provide Evidence of Earnings & GP Sick Note(s)  | YES / NO  |

**IN ORDER TO AVOID ANY DELAY IN YOUR CLAIM BEING PROCESSED PLEASE ENSURE**:

 **TICK**

* THE CLAIM FORM HAS BEEN COMPLETED, FULL PAYEE DETAILS PROVIDED AND FORM IS SIGNED
* THE MEDICAL CERTIFICATE HAS BEEN COMPLETED BY TREATING PRACTITIONER IF APPLICABLE
* ALL RECEIPTS/INVOICES FOR TREATMENT (BODY PART TREATED MUST BE IDENTIFIED) ARE ATTACHED

* 1. Injured Person:

|  |  |  |  |
| --- | --- | --- | --- |
| Name   |   | Date of Birth  |   |
| Address  |   |  |
| Post Code  |    |
| Telephone Number   |   | Email Address  |   |
| BG Membership Number   |   | Level of Membership  |   |
| Name and Address of Club  |      |  |
| Currently Employed   | **YES / NO**  | Usual Occupation  |   |

* 1. Date and Time of Accident:

|  |
| --- |
|    |

* 1. State briefly how and where the injury occurred, providing full details of the agility/activity being attempted:

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|          |

* 1. Details of Injury Sustained:

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* 1. Name & Address of Witnesses:

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|        |

* 1. Please provide your Doctors / Dentist name and full address

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* 1. Type of Medical Expenses Claimed For:

|  |
| --- |
|    |

Name & Address of the specialist providing treatment (please ensure the specialist complete the medical certificate)

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* 1. Who advised you to seek this medical treatment? Name and relationship (e.g. GP, Coach etc)

|  |
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* 1. Name of Doctor / Consultant and Address (if claiming for Hospital benefit) The doctor must complete the certification information below

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| --- |
|  Hospitalisation Certificate  To the Claimant – Please ask the treating doctor to complete this form  To the Doctor – Please complete the information below:  I, the undersigned herby confirm that   |
| Patients Name:   |   |
| As a sole result of the accident which occurred on:   |
| Date of Accident:   |   |
| Was an inpatient at (name of hospital)   |   |
| Date / Time the patient was:   |
| Admitted   |   |
| Discharged   |   |
| Signed   |   | Date  |   |
| Qualifications   |   |

* 1. Details of any travel or accommodation expenses incurred:

|  |
| --- |
|       |

 What is the relationship between the person claiming under section 10 and the injured person?

|  |
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|    |

* 1. Loss of Earnings as a Coach

Please note that insurers do not pay for the first 14 days of any Period of Disablement

What is your average weekly income from Coaching

|  |
| --- |
|    |

Please attach:

* 1. Evidence of your earnings for the 13 weeks prior to the incident and wage slips issued during your absence in respect of coaching / trampolining.
	2. Sick notes from your GP confirming you are unable to coach

If your claim is successful, please confirm who any cheques should be made payable to (Full Name)

|  |
| --- |
|    |

*Please note that if the payee information is provided with initials only this will result in a delay in the payment process.*

Alternatively, if you would prefer any payment via BACs please provide your bank information on the attached sheet. These details will be retained only until your claim is concluded and will then be destroyed in accordance with Data Protection requirements.

DATA PROTECTION:

All information you provide on this form is treated by us as confidential and except to the extent required by law, we shall only use such information for the purpose of processing your claim. Information you provide may be forwarded to your Insurer for these purposes.

Declaration by all applicants

I confirm that to the best of my knowledge the above information is correct.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature  |   | Date  |   |
| Print Name  |   |

Claimant / Patient / Guardian (mark appropriately)

Medical Certificate

(To be completed by the treating practitioner)

|  |  |
| --- | --- |
| This is to certify that (name of patient)   |   |
| Is suffering from (nature of injury  |     |
| Date of Injury   |   | Date of treatment Commenced / to commence  |     |
| Is there any history of a similar previous injury?   | YES / NO  |
| If yes, please provide details:  |    |
| How frequently do you anticipate providing treatment?   |  |
| How long is treatment likely to continue for?   |  |

Please note that if treatment continues for more than 12 weeks a further medical certificate regarding the updated prognosis and recovery period will be requested.

Are there any factors which might have contributed to the injury which might delay recovery?

YES / NO

If yes, please provide further details:

|  |
| --- |
|      |

Your Address:

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|  |  |
| --- | --- |
| Qualifications  |    |
| Signature  |  |
| Print Name  |  |
| Date  |  |

**Note for Doctors – Any fee for this certificate is to be paid by the patient**

Bank Information for BACS Payments

***Please note that insurers are unable to issue a payment if they are not provided with the full first and surname(s) of the account holder(s).***

***If payee information is provided with initials only this will result in a delay in the payment process.***

|  |  |
| --- | --- |
| Full Name(s) of the Account Holder(s)  |    |
| Sort Code  |  |
| Account Number  |  |
| Bank Name  |  |
| Bank Address   |  |