GAA INJURY Benefit Fund

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 / Laya Health Care / Irish Life Health / Department of Employment Affairs and Social Protection / Department for Communities to supply any information requested. I understand that any deliberate misstatement wi l void the claim in its entirety.

I am aware that 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 will be held and assessed by DWF Claims and the GAA.

By ticking this box, I consent for the purposes of the General Data Protection Regulation and the Data Protection Act 2018 to data concerning my health (e.g. nature of injury) to be processed by the GAA and DWF Claims in order to assess this claim.

☐ (Please note, if you do not tick this box, your claim cannot be processed, as the nature of your injury is required).

I give my authorisation that any information pertaining to this claim may be provided, only when necessary to any persons deemed relevant by DWF Claims and /or GAA in assessment of this claim.

Name (block capitals)

Signature Date

Team Trainer's Declaration

I declare that the above-named claimant was injured as a result of participating in an Official Fixture as recorded in the Referees report. Yes No

I declare that the above-named claimant was injured as a result of participating in an Official Supervised Training Session \ or an Official Sanctioned Match Challenge Match (delete as applicable)

Yes No

Name (block capitals)

Signature Date

Passed by Club Secretary \ Designated Injury Fund Administrator

I declare that the above-named claimant is a registered member who

was injured as a result of participating in an Official Fixture as recorded in the Referees report submitted.

Yes No

was injured as a result of participating in an Official Supervised Training Session \ or an Official Sanctioned Challenge Match (delete as applicable), letter submitted from Club Secretary \ Injury Fund Administrator on official club headed paper confirming same Yes No

Membership number

Name (block capitals)

Signature Date:

MEDICAL CERTIFICATION – FOR COMPLETION IN ALL CASES BY THE DOCTOR/DENTIS ONLY WHO ATTENDED THE CLAIMANT.

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

Web Reference [ ]

Patient's Name [ ]

Patient's Date of Birth [ ]

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? Yes [ ] No [ ]
If Yes, please give date and detail

[ ]

[ ]

Please Indicate if this injury is GAA related Yes [ ] No [ ]

Please indicate if the claimant has suffered an accidental bodily injury 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.

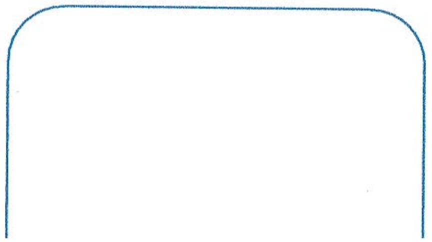
Name (block capitals) [ ]

Signature [ ]

Telephone Number [ ]

Date [/ /]

Stamp
(if no stamp available a business card or



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

Web Reference [ ]

Employer's Name [ ]

Phone Number [ ]

Company Registration Number [ ]

Address [ ]

[ ]

Employee's Name [ ]

Employee's RSI Number [ ]

Employee's RSI 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 official payslips dated prior to the date of injury)

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 / Managers Name (block capitals) [ ]

Personnel Officer's / Managers Signature [ ]

Date [ ]

Employer's Stamp
(if no stamp available please attach a letter