Cumann Peil Gael na mBan

The Ladies Gaelic Football Association

LGFA PEIL na mBAN

INJURY FUND CLAIM FORM

ALL SECTIONS OF THE FORM ARE TO BE COMPLETED TO THE BEST KNOWLEDGE OF THE CLAIMANT. THIS FORM SHOULD BE COMPLETED IN BLOCK CAPITALS. ALL SIGNATURES MUST BE COMPLETED ON THE LAST PAGE OF THIS CLAIM FORM.

ALL TERMS AND CONDITIONS OF THE LGFA INJURY FUND MUST BE ADHERED TO IN ORDER FOR EXPENSES TO BE REIMBURSED. IT IS THE INJURED PARTY'S RESPONSIBILITY TO ENSURE THEY HAVE REVIEWED AND ADHERED TO THE TERMS OF THE LGFA INJURY FUND.

SECTION A

Claim number:

Name: (As per registration)

Date of Birth: D M Y

Address:

Eircode

Telephone Number:

Mobile Number:

Player registration number

Email Address:

Registered with: Club County

Are you involved with other sports: *(Please Specify)*

Employment Status *(Please tick as appropriate)*

Student Employed Self Employed Unemployed

Private Medical Insurance: Yes No

Medical Card No:

VHI:

LAYA:

Irish life:

HSF:

Employer Medical Aid Scheme:

Schools 24/7 Personal Accident Policy:

Other Insurance: *(Please Specify)*

THE INJURY FUND IS NOT AN INSURANCE SCHEME. PLAYERS WHO HAVE MEDICAL INSURANCE MUST CLAIM FROM THEIR POLICY AND SUBMIT A STATEMENT OF ACCOUNT OF THEIR MEDICAL CLAIM.

FULL TERMS AND CONDITIONS ARE AVAILABLE ONLINE AT LADIESGAELIC.COM/RESOURCES/INJURYFUND AND SHOULD BE REVIEWED BEFORE PROCEEDING WITH ANY TREATMENT YOU WISH TO HAVE REIMBURSED BY THE FUND.

SECTION B

Date of Injury: Nature of Injury (Example Head/Leg/Chest)

Brief Details of how injury occurred:

Injury occurred at the following:

Club: **Training:**

County: **Official Match:**

Have you already opened a claim in relation to this injury? Yes No

SECTION C

To be completed if claiming loss of wages (Please enclose last 4 payslips & doctors certificate signed on your return to being fit to work)

Employer's Name/Company Telephone Number

Address

Were you disabled by your injury, unfit to attend work and unable to earn an income?

Dates when absent from work

Amount of Benefit paid to you by Department of Social Welfare?
(Please enclose letter from the above Department stating amount paid to you)

Were you paid by your Employer while injured?

Had you income from any other source while injured?

(Please Specify)

TO BE COMPLETED BY EMPLOYER Date employment commenced

Gross Weekly Wage Nett Weekly Wage Date Missing Date Returned

I declare that the above was/not paid by me while injured during the dates stated above.

Employer's Registration No.

Signed:

Employer's Stamp

If no stamp available Please include a letter On Company Headed Paper confirming the Above details.

Loss of Wages Certification - For Self Employed:

I declare that I am unfit for work as a result of participating in Ladies Gaelic Football and am unable to earn my nett weekly income.

I attach (i) Certificate from my Doctor
(ii) Confirmation of loss of nett weekly income from my Accountant (include Chartered Accountants Registration No).

SECTION D

Total Expenses being claimed for this injury.
Please complete all sections of table below

	Name	Amount	Office use only
Physical Therapy/ Physiotherapy			
G.P			
Public Hospital Expenses			
Consultant			
Scan: MRI/Xray Etc			
Surgery			
Consultant Anaesthetist			
Hospital			
Loss of Wages			
Dentist			
Other			
Total			

All expenses submitted must be in accordance with the terms of the LGFA Injury Fund.
Any expenses not reimbursable will be returned.

SECTION E - ALL SECTIONS MUST BE COMPLETED

I declare that I am a registered member of the Association and give permission to Central Council of Cumann Peil Gael na mBan or their representatives to make any enquires that they deem necessary and that all information contained is correct.

Injured Party's Name:

Injured Party's Signature: Date:

IN THE EVENT OF A JUVENILE INJURY, TO BE COMPLETED BY INJURED PARTY'S PARENT/GUARDIAN:

Name of Parent/Guardian of under 18 Player:

Signature of Parent/Guardian of under 18 Player: Date:

TO BE COMPLETED BY THE TEAM TRAINER'S SIGNATURE:

I declare that the above sustained this injury in a team training session/match under my supervision.

Team Trainer's Name:

Team Trainer's Signature: Date:

CLUB SECRETARY'S DECLARATION:

I declare that the above is a registered member of our club and sustained this injury while participating in the activities of Cumann Peil Gael na mBan.

Club Secretary's Name:

Club Secretary's Signature: Date:

COUNTY SECRETARY'S DECLARATION:

I declare that the information supplied by the claimant is correct.

County Secretary's Name:

County Secretary's Signature: Date:

To Be Completed By County Secretary:

Any omissions will result in the form been returned for completion and may cause delays in settlement.

Check List:

Are all original receipts included? **Yes** ☐ **No** ☐

Are all Sections of the form completed? **Yes** ☐ **No** ☐

Has the form been signed by

(i) The Injured Player **Yes** ☐ **No** ☐

(ii) Person in charge of team **Yes** ☐ **No** ☐

(iii) The Club Secretary **Yes** ☐ **No** ☐

(iv) County Secretary **Yes** ☐ **No** ☐

Full details of the benefits and terms of the LGFA Injury Fund are available online athttps://ladiesgaelic.ie/resources/injury-fund/.