Sports Insurance

Group Personal Accident Insurance | Claim Form

PLEASE COMPLETE THE FOLLOWING CLAIM FORM IN BLACK INK AND BLOCK CAPITALS IF POSSIBLE.

Thank you for notifying us of your potential insurance claim. Please make sure that ALL questions are completed and if any section is not applicable to your specific claim, please state N/A. Once the entire form is completed please return it to the following;

Sportsguard, One Overstone Heights, Sywell, Northamptonshire, NN6 0AT **or if you have any questions contact;** Sportsguard on 01604 644277

Club Details (to be completed by the policy holder)

Full Name of Club: _____ Policy Number: _____

Full Club Address: _____

_____ Postcode: _____

Contact Name at Club: _____ E-mail: _____

Affiliated Association: _____ Phone No: _____

Adult Claimants - Please complete all sections and send us your last two wage slips and all sick notes issued to date.
Youth Claimants - Please complete all sections unless they are marked Adults Only in the background.

Claimant Details (to be completed by the injured person or their legal parent/guardian)

Full Name: _____ Date of Birth: _____

Full Address: _____

_____ Postcode: _____

Employment Status: **Employed/Self Employed/Unemployed/Full Time Student** - *Please delete as appropriate*

Occupation: _____ Home: _____

Position in Club: _____ Mobile: _____

Email: _____

Claimant Declaration (which needs to be signed by the injured person or their parent/legal guardian)

I certify that the following statements are correct. I understand that some of the information I have provided will be made available to Sportsguard and other insurers for underwriting, claims handling purposes and fraud prevention. I consent to the seeking of information to check the answers I have provided, and I authorise the giving of such information.

Paper documents submitted with this claim form are held by Sportsguard for a period of 30 days from submission, then destroyed. Electronic versions are kept on our secure server. We suggest you submit photocopies of your documents i.e. wage slips, sick notes, etc...

Signature: _____ Date: _____

Employment Details (to be completed by the injured persons employer)

Full Name of Company: _____ Date Started: _____

Address of Employer: _____

_____ Postcode: _____

Company Contact Name: _____ Phone: _____

Position in Company: _____ Email: _____

Signature: _____ Date: _____

Self Employed Details

If you are self employed then we require a copy of your last years accounts or a letter from your accountant detailing your income for the year prior to the accident.

Please state your National Insurance Number: _____

Accident Details (to be completed by the injured person)

Please give the exact date and time when injured: Date _____ Time: _____ am/pm

Please state fully:-

a) Where the accident occurred: _____

b) How the accident occurred: _____

c) The injuries sustained: _____

d) What Sport were you playing: _____

e) What were you doing at the time of the injury (please circle): 11 a-side 7 a-side 5 a-side Training Other: _____

f) If this was a match, who were your opponents: _____

g) What was the officiating referees name: _____ Phone Number: _____

h) When did you first seek medical attention: _____

i) Date you were unable to attend your normal occupation: _____

j) Have you ever suffered from this or any connected disability: **Yes/No**
if Yes, give full details, including dates: _____

k) Have you previously claimed through a Sportsguard policy: **Yes/No**
if Yes, give full details, including dates: _____

l) Please provide the full name and address of the Doctor who attended to you and the full name and address of your usual doctor:

Accident and Emergency Department

Full Name: _____

Full Address: _____

Usual Doctor

Full Name: _____

Full Address: _____

Doctors Statement (to be completed in ALL cases)

This section must be fully completed by the claimants usual General Practitioner (G.P.) or a duly qualified medical practitioner.
ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE CLAIMANT

Patient's Full Name: _____

Date of Birth: _____ Height (approx): _____ Weight (approx): _____

Final Diagnosis: _____

_____

When did the patient first receive medical attention for this condition: _____

Has the patient ever suffered with this or any similar condition before the present disability: Yes/No
If Yes, please give details including dates and treatment: _____

At the time of the accident was the patient suffering from any illness or disease: _____

How long has the patient been registered with you: _____

When do you anticipate the patient to return to partial duties: (adult patients only) _____

When do you anticipate the patient to return to full duties: (adult patients only) _____

If the patient has already returned to full duties, state the date: (adult patients only) _____

In your professional opinion do you believe this to be a sports related injury: _____

Signed: _____ Date: _____

Doctors Full Name: _____

Qualifications: _____

Please validate this section by using an official stamp.

Validation Stamp

Hospital Statement (Only to be completed if claiming for the hospitalisation benefit)
This section must be fully completed by hospital medical staff or you can submit your medical records (admittance/discharge notice).
ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE CLAIMANT

Type of hospital/ward: _____

Name of Doctor or Consultant in charge _____

The dates admitted and released: **ADMITTED:** _____ **RELEASED:** _____

Signed: _____ Date: _____

Validation Stamp

Doctors Full Name: _____

Qualifications: _____

Please validate this section by using an official stamp or enclose your discharge notice.

Your rights - please read carefully

ACCESS TO MEDICAL REPORTS ACT 1988 - Before your attending doctor can give a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:-

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the doctor to amend any part of the report you consider to be incorrect or misleading. If the doctor does not agree with your request you may attach your comments to the report.

NB: The doctor may withhold all or part of the report from you if he/she considers that you may be physically or mentally harmed by it.

Patient Declaration:
Having been made aware of my statutory right under the Access to Medical Reports Act 1988 in connection with my claim.

1. I hereby consent to Sportsguard and their insurers seeking medical information from any doctor who at any time has attended me concerning my conditions which affect my physical or mental health.
2. ❑ I **DO** wish to see the report before it is sent to Sportsguard and their insurers.
   ❑ I **DO NOT** wish to see the report before it is sent to Sportsguard and their insurers.
3. I authorise such doctor to disclose such information.
4. I agree that a copy of this consent shall have the validity of the original.

Signature _____ Date _____

If you are claiming for a child or minor, please can a parent or legal guardian sign this section.

Data Protection Act 1988

We will fairly and lawfully collect and record personal information that is supplied within and as a result of this form. We shall share information with your underwriters and their agents and, in certain cases, with other underwriters to help detect and prevent fraudulent claims. We require your consent to process information in this way and by completing and signing this form you are explicitly providing that consent.

Preferred Payment Method

If your claim is agreed how would you like to be paid? **Please note: If you do not supply bank account details we will send a cheque.**

Cheque ❑ Confirm Your Full Name: _____

BACS (Bank Transfer) ❑ Account Holder Name: _____

Account Number: _____

Branch Sort Code: _____

If your claim is agreed we give you the choice of getting paid once you have returned to work (in a lump sum) or with interim payments.

I would like to be paid with interim payments ❑ (only available to claimants in full/part time employment)
or, when I have returned to work ❑

Administration Use Only - Do not complete this section, office use only.

Claim Reference Number: 3813m

Club Official Approval Statement (to be completed by an official of the football club, present at the time of the injury)

This section of the form must be completed by a Club Official present at the time of the injury.
In the last two years there have been a number of fraudulent claims made by players throughout the UK, which is why we are asking clubs to be completely involved in any claim put through via their club. At Sportsguard we want genuine claims to be paid, however if the schemes get abused, the premiums will go up and clubs may lose the facility.

We are asking for your co-operation in order to protect the clubs policy from being abused, which is ultimately in everyone's interest.

Please note, the policy you have is cover for players and officials whilst playing, training or on football duties for YOUR team, it does not include practice sessions that are organised by the players, nor does it include players who participate in various different teams.

Please confirm the following details

Name of injured person: _____

Position of the injured person in club: _____

Where did the accident happen: _____

Name of Official on Duty (*must be different to the injured person*): _____

Was first aid given or offered: _____

Who administered the first aid: _____

If the injury was at a training session, was the injury reported to the on duty official at that time: Yes/No

If a club official has not witnessed the accident then it is not covered as the incident cannot be verified by the policy holder.

I/we declare that all of the information given above is that of my best knowledge and belief, in the event of a fraudulent claim, I/we may be held liable for fraudulent payments to the injured person.

Signature by the club official on duty (*as above*): _____ Date _____

Signature by the club secretary: _____ Date _____

Please note: *That all fraudulent claims will be declined and you and your club may be held liable.*

Claim Form Checklist

1. Page 1 of the claim form needs to be completed in its entirety, youth do not need to complete the employers section. — Yes Completed ❑

2. Page 2 of the claim form (Accident Details) needs to completed by the injured player. We also require (Doctors Statement) to be completed by a medically qualified practitioner. — Yes Completed ❑

3. Page 3 of the claim form (Hospital Statement) needs to be completed if you are claiming for a hospital confinement benefit, please consult Sportsguard or your club to see if you are insured for this benefit. — Yes Completed ❑
On page 3 you must complete the Rights to a Medical Report Section, by choosing either option shown, you must also sign this section. — Yes Signed ❑

4. Page 4, please give the claim form back to the club and allow them to complete the Approval Statement, all the answers in this section will be cross checked with the club and league. — Yes Completed ❑

5. You **must** enclose all medical sick notes you have been issued to date, Adults Only. — Yes Enclosed ❑

6. We require two of your last wage slips, immediately prior to the date of the incident, Adults Only. — Yes Enclosed ❑

7. Dental Claims must include a itemised invoice from the dentist. You can ignore steps 3, 4, 5 and 6. — Yes ❑ Not Applicable ❑

8. **Before you submit anything to Sportsguard, please make a photocopy to keep for your records.** — Yes Required ❑