DDSL CLAIM FORM

To be completed by the injured parties parent/guardian and countersigned by an official

AVIVA

Membership Number : **Claim Reference:** **TBA**

Name of Injured member: **Date of Birth:** ___/___/___

Contact Number: **Email Address:**

Full Address:

Please state affiliated club:

PPS Number:

Do you hold private health insurance or have any other policy in place to cover this claim Yes ☐ No ☐ **Medical cardholder:** Yes ☐ No ☐

Please give details including Insurer Name and Plan Name:

Details of Accident

Date of Accident___/___/___**Location of Accident:** _____

How did it happen? Please give full details _____

_____

Please give details of the fixture if applicable _____

Name & Number/Email of Witness _____

Details of Injury

What injuries have you sustained? _____

Have you suffered a similar injury in the past? Yes ☐ No ☐

If yes, please give particulars including the date of the injury and when you returned to sport_____

_____

Doctor

Name and address of Doctor _____

Is he/she your usual Doctor? Yes ☐ No ☐

I warrant the truth of the foregoing statements and enclose original supporting documents as required

Signature of Official _____ **Position:** _____

Signature of Claimant _____ **Date** ___/___/___

Bank Details

Name of Account Holder _____

BIC																					
IBAN																					

The details above must represent a current account and will be the account we pay any settlement amounts to. By giving us your BIC and IBAN you authorise us to contact you via telephone when we have calculated your settlement offer to confirm that you are happy to waive your right to wait 10 business days to accept or reject the offer. We will then arrange for the funds to be transferred directly to your account via EFT.

MEDICAL CERTIFICATE. To be answered in full by a registered medical practitioner only **(not physiotherapist).**

Name of Patient:_____

What injuries has the Patient sustained? _____

_____

What date did the injury occur? ____/____/____

What course of treatment has been recommended in respect of this injury? _____

_____

_____

When were you first consulted about the above injury? ____/____/____

How long has the Patient been totally or partially disabled from engaging in or attending to any business as the result solely of the injuries?

Totally From ____/____/____To____/____/____

Partially From ____/____/____To____/____/____

How much longer do you consider such disablement will continue?

Totally From ____/____/____To____/____/____

Partially From ____/____/____To____/____/____

Has the Patient any disease or any physical defect and if so of what nature?

To what extent may recovery be affected by this?

Are the injuries sustained as a result of a pre-existing condition/injury? If so, please details;

Qualifications _____Signature _____

Address _____

_____

Date ____/____/____ Official Stamp:

Please note, reduced policy limits will apply in respect of claims for physiotherapy treatment and emergency dental treatment – please refer to your insurance certificate for full details.

POLICY COVER

Bodily injury sustained by any registered member whilst engaged in playing, training or travelling affiliated with the DDSL

Benefit	Cover
Death	€25,000
Permanent Disablement	€80,000
Medical Expenses	€10,000
Physio	€250
Emergency Dental	€1,000 (€100 excess applies)
Excess	€50 / 10% of total claim

Medical Expenses Key Points:

Please note your private health insurer is the first port of call and this policy, only caters for Medical Expenses which are irrecoverable elsewhere. Cover is provided for limited Physiotherapy Expenses where there is a requirement for same pre or post-surgery.

Cover for physiotherapy is only provided where referred by an attending approved Medical Practitioner/Physio.

Principal Exclusions:

All preexisting injuries are excluded.

The first €50 or 10% of the over all claim (€100 for dental) in respect of incurred Medical Expenses.

An accident proved to have occurred due to the influence of alcohol or drugs.

Please notify all incidents within 30 days

Checklist:

Please return this checklist with your claim form and any supporting documentation to: paclaims@leesongroup.com or post to **Leeson Claims Services Ireland,** 68 Merrion Square South, Dublin 2

Contact: Elizabeth Brohoon – 01 4852988/01 4852980

Documents to enclose with your claim form:	Tick

Fully completed claim form and medical certificate (form must be countersigned by an official). This will be returned to you if any field is left unanswered.	
Original receipts and invoices for medical expenses incurred. Photocopies will not be accepted. (If the player holds private health insurance he/she must submit a claim through the private health insurer first as the Clubchoice policy only covers irrecoverable expenses).	
Physiotherapy/Alternative treatment will only be considered where a referral letter from a medical practitioner has been obtained.	
For any surgery required that is covered under the policy, we require a pro-forma invoice from the hospital 4 weeks in advance stating the date of the surgery, the breakdown of the costs, and who to make the cheque payable to. This is subject to the policy excess and policy limits under the medical expenses section of the policy.	