CLUBCHOICE CLAIM FORM

To be completed by the injured player

Please return to: Dolmen Insurance Brokers, Butterly Business Park, Artane, Dublin 5

Insured Club: **Claim Reference:**

Details of Claimant

Name of Injured Party: **Date of Birth:** ____/____/____

Full Address: ______________________________

Precise Occupation: ______________ **VHI Number:** ______________

PPS Number: ______________ **Medical cardholder:** Yes/No

Details of Accident

Date of Accident ____/____/____ **Location of Accident** ______________

How did it happen? ______________________________

Did the injury occur during a match or whilst training? ______________________________

Please give details of the fixture if applicable ______________________________

Name & Address of Witness ______________________________

Details of Injury

What injuries have you sustained? ______________________________

Have you suffered a similar injury in the past? Yes/No (please delete as appropriate)

If yes, please give particulars including date ______________________________

How long have you been disabled from engaging in, or attending to any business or occupation because of this injury?

(a) Totally From ____/____/____ **To** ____/____/____

(b) Partially From ____/____/____ **To** ____/____/____

If you have attended hospital please complete the following information:

Name of Hospital	Date of Admission	Time	Date of Discharge	Time
	____/____/____		____/____/____	
As an In-Patient	Yes/No		**As an Outpatient**	Yes/No

Doctor

Name and address of Doctor who is attending you ______________________________

Is he/she your usual Doctor? Yes/No

It is necessary that the questions overleaf be answered by a registered medical practitioner

Other Insurance

Do you have any other insurance insurance in place to cover this claim? Yes/No

If so, please give particulars (including the policy number) ______________________________

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

Signature of Club Official ______________ **Position in Club**______________

Signature of Claimant ______________ **Date** ____/____/____

Medical Certificate
To be completed by a registered medical practitioner only

Name of Patient ______________________________

What injuries has the Patient sustained? ______________________________

____

What course of treatment has been recommended? ______________________________

____

When were you first consulted? ____/____/____

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 thereby?

Are the injuries sustained as a result of a pre-existing condition? If so, please detail

Qualifications ______________________________ Signature ______________________________

Address ______________________________

____

Date ____/____/____ Official Stamp