SPORTSCOVER EUROPE

Player Accident
Claim Form

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Registered in England and Wales No. 3726678
Authorised and regulated by the Financial Conduct Authority
Registration Number 308372

www.sportscover.com

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Player Accident
Claim Form

Dear Member

When you are completing this claim form please ensure that you have read the accompanying policy wording fully and you are aware of your obligations under the policy terms and conditions as your request for benefits will be assessed in accordance with these terms and conditions.

Please make sure all sections of this form are completed and returned.

1. Please ensure that the club Secretary/Treasurer completes the Official Report section of the claim form.
2. Please make sure that you sign and date the Declaration and Authorisation.
3. Please enclose all original receipts for medical expenses (if applicable) after you have first claimed from your private health insurer or any other source from which you are entitled to claim.
4. The Physicians Statement must be completed by the main doctor, chiropractor or physiotherapist who is providing the treatment for your injury. Physiotherapy costs will only be paid if the physiotherapy has been recommended or ordered by a qualified medical practitioner and evidence of this must be provided.
5. For claims under the “Lump Sum” Net Loss of Income benefit your Employer must complete the Employers Statement. If you are self-employed we require a financial statement completed by your accountant to show the income you have earned over the previous 12 months.
6. To obtain the maximum payment please ensure you apply for your government entitlements under the social welfare benefit provisions from the day of injury or as soon as practical thereafter.
7. Claims cannot be settled until all treatment relating to the injury has been completed and all accounts have been paid and refunds from your private or occupational health insurer have been obtained.
8. For Claims relating to income lost, a Return to Work Statement from your employer is also required before processing can be completed.
9. Please complete the details on Page 15 for faster payment direct to your bank account. Alternatively, we can post your claim payment to you as a cheque drawn on a British bank. You should note that you will be responsible for any charges your bank may make to pay in the cheque.

The claim form should be returned with any accompanying documents to the address of:

Your broker who supplied the claim form to you.

Office use only:	Claim No:	Policy No:

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Accident information

	Claimant information		
1	Name		
	Address		
		Postcode:	
	Telephone number	Home:	
		Work:	
		Mobile:	
	Email address		
2	Club name		
3	Association name		

	Accident information		
4	Personal details		
	Date of birth		
	Occupation		
	Average weekly earnings	Currency	
		Amount	
	Sex	Male	Female
5	Please give a full description of the circumstances of the accident which resulted in injury		
6	If you were engaged in team sport, please specify the grading of the team	Senior	Junior

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7	Details of any witness to the accident			
	Name			
	Address			
		Postcode:		
	Telephone number	Home:		
		Work:		
		Mobile:		

8	Who is the club official to whom the injury was reported?	Name		
		Position		

9	Give the exact details when the injury occurred	Date		
		Time	AM	PM

10	Where did the accident occur?

11	What injuries did you receive?

	Medical detail			
12	Have you ever had this injury, or similar injury in the past?	Yes:	No:	*(if yes, give details below)*
	Date			
	Treated by			
	When did you first consult a doctor for this injury?	Date		
		Time	AM	PM

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13	When did you first consult a doctor for this injury?	Date		
		Time	AM	PM
	If still disabled, what date do you expect to return to work?			
	If you have returned to work, what date was this?			

14	Were you admitted to hospital or treated by a physician?	Yes:	No:	*(if yes, give details below)*
	Name of hospital			
	Address			
		Postcode:		
	Dates	From		To
	As an	Inpatient	Outpatient	
	Name of attending doctor			

15	Who is your usual family doctor?	
	Name	
	Address	
		Postcode:
	Telephone number	

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16	What expenses do you wish to claim?			
	Note that original receipts and all statements of any benefit received or to be received from private health insurance must accompany this claim form. Failure to comply will result in delays in claim settlement.			
	First expense			
	Service provided by			
	Nature of service			
	Date of service			
	Cost of service	Currency		
		Amount		
	Private health insurance refund	Currency		
		Amount		
	Second expense			
	Service provided by			
	Nature of service			
	Date of service			
	Cost of service	Currency		
		Amount		
	Private health insurance refund	Currency		
		Amount		

17	Have you received medical or surgical treatment during the past five years?	Yes	No	*(if yes, give details below)*
	Date			
	Nature of injury			
	Doctors name			
	Doctors address			
		Postcode:		

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18	Are you now, or have you ever been, subject to or affected by other injury or disease, deformity, defect of senses, infirmity or weakness?	Yes	No	*(if yes, give details below)*

19	Are you a member of a private health insurance fund?	Yes	No	*(if yes, give details below)*
	Fund name			
	Member number			

20	Are you making, or entitled to make, a claim in respect of this injury for any of the following?	
	Sick leave	Workers compensation
	Motor compensation	Other government benefits
	Superannuation life insurance	

Declaration and authorisation by injured person

I hereby authorise any hospital, physician or other persons who has attended me, or any employer, to furnish Sportscover Europe Ltd or their authorised representative with any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I declare that the preceding statements and information are to the best of my knowledge and belief true in every respect and are an accurate reflection of the circumstances expenses and likely offsets surrounding my claim.

Signature

Date

Important note: Any errors, omissions or discrepancies will affect the settlement of your claim.

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Official report

To be completed by the club secretary or treasurer.
Please ensure that all questions have been fully answered.

21	Name			
	Position			
	Address for correspondence			
		Postcode:		
	Telephone number			
22	Name of club			
23	Grade player was playing in at the time of the accident			
24	Was the player above registered at the time of the accident?	Yes	No	*(if yes, give details below)*
	Registration number			
	Date of registration			

25	Were you a witness to the accident described?	Yes	No
	If yes, please provide details of the event		
	If no, please provide the details of a witness to the event		
	Name		
	Address		
		Postcode:	
	Telephone number		

Declaration of club official

I certify that the particulars shown on this form by the player are, to the best of my belief and knowledge, true and correct.
Signature
Date

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Physicians statement

To be completed by the main doctor, physiotherapist, or chiropractor.
The insured is responsible for the completion of this form without expense to the company.

26 Patient's name

Patient's address

Postcode:

27 What is disabling the patient? *(please give a complete diagnosis of the condition)*

History

28 When did the patient first receive medical treatment?

29	Was there a previous history of this or a similar condition?	Yes	No	*(if yes, state condition and advise when previous treatment was given below)*

30 How long have you known the patient?

31	Are you the regular general practitioner?	Yes	No	*(if no, advise who is below)*

	Injury (if applicable)			
32	When did the patient suffer injury?			
33	What were the circumstances surrounding the injury?			
34	Patient's occupation			
35	When was the patient obliged to cease work?			
36	If patient is still disabled, when approximately will the patient resume	Some duties		
		Full duties		
37	If patient has recovered, when was the patient able to resume	Some duties		
		Full duties		
38	When were you consulted?	Initially		
		Most recently		
39	How often has this patient consulted you?			
40	Was the patient confined to hospital?	Yes	No	*(if yes, give details below)*
	Name of hospital			
	Period of confinement	From		
		To		
	Was confinement in a convalescent home necessary after the hospitalisation?	Yes	No	*(if yes, give details below)*

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41	What are the current subjective symptoms?			
42	What surgical procedures have been performed?			
43	What surgical procedures are contemplated?			
44	Are there any underlying conditions affecting recovery from the current condition?	Yes	No	*(if yes, advise nature of underlying conditions and how they affect disability and recovery)*
45	If you have terminated treatment, please advise date			
46	What is the current prognosis?			
47	Is there any permanent disability at present?	Yes	No	*(if yes, explain giving estimated percentage loss of function below)*

Signature

Date

Degree

Name (please print)

Address

Postcode

Telephone number

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Employment details

To be completed only if you intend to claim for the lump sum net loss of income benefit.

Note:

- A claim cannot be made unless the claimant was fully employed and earning at the date of injury.
- The claimant must be continuously and totally disabled for more than ten days.
- The ten days of disablement is not covered.
- Your claim for benefits from all other sources must be lodged prior to settlement of this claim.

48	Personal details		
	At the time of the accident, were you	A full-time employee	
		Self employed on a full time basis	
	Marital status	Married	Single
	Number of dependent children		

49	As a result of the accident period of total disablement described in this claim are you entitled to a sickness benefit through social welfare?	Yes	No

50	Please give details of your entitlement to any of the following benefits		
	Employer sick pay	Weeks	Currency
		Amount	Total
	Social welfare benefits	Weeks	Currency
		Amount	Total
	Other insurance benefits *(including personal accident policies)*	Weeks	Currency
		Amount	Total
	Other payments *(salary, wages, income or payments of whatsoever nature)*	Weeks	Currency
		Amount	Total

51	What was your annual income from all sources in the twelve months prior to your accident?	Currency
		Amount

Employees statement

	Details of your employer or employers during the twelve-month period prior to your accident.		
52	Current employer		
	Full company name (no abbreviation)		
	Contact		
	Address		
		Postcode:	
	Telephone number		
	Period of employment	From	To

Employer statement

	To be completed by the employer. The insured is responsible for the completion of this form without expense to the company		
53	Name of employee		
	Commencement of employment		
	Date of injury		
	Days sick pay entitlement		Days
	Gross earnings in past 12 months prior to injury	Currency	
		Amount	
	Remuneration since injury	Currency	
		Amount	

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Declaration of Employer

I confirm that the above-named employee has been employed continuously by this firm since the date stated above. Their gross earnings since the above date of employment (if less than 12 months) or for the past 12 months up to the date they were unable to work as a result of the sporting injury described on this claim form amounted to the sum stated above. At the date of injury stated above the claimant / employee was entitled to the above stated sick days pay.

I confirm that the claimant / employee was not entitled to receive nor did receive any form of remuneration whatsoever from this firm, his employer in respect of his / her period of disablement commencing at the above-mentioned date of injury except as stated above.

I declare the above information to be true and correct.

Signature

Name (please print)

Position

Full company name

Company address

Postcode

Date

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Accountants statement

	For self employed persons only. To be completed by the claimant's accountant.
54	Claimant name
	Date of injury
	Contact
	Gross earnings (before tax but after expenses for 12 month period ending the injury date stated above — Currency / Amount

I confirm that our firm acts as accountants for the claimant stated above and that his gross earnings (before tax but after expenses) for the 12 month period ended the injury date stated above amounted to the sum stated above. I declare the above information to be true and correct.

Signature

Name (please print)

Position

Full company name

Company address

Postcode

Date

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Witness statement

	We require a statement from anyone who witnessed your accident. Please have that person complete this section.
55	Witness personal details
1	Name
	Address
	Postcode:
	Telephone number

56	Please give a full description of the accident giving rise to the claimant's injury as you saw it.

Signature
Date

Sportscover Europe Limited
Second Floor
153 Fenchurch Street
London
EC3M 6BB

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Web: www.sportscovereurope.com

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Payment details

These details will allow us to make your claim payment directly to your bank account. Should you prefer, we can post your claim payment to you as a cheque drawn on a British bank. You should note that issuing a cheque will be slower than direct settlement and you will be responsible for any charges your bank may make to pay in the cheque.

Please provide all of the requested information below. We will write to you to advise that the payment has been made.

Name of account holder	
Bank name	
Bank address	
	Postcode:
IBAN	
SWIFTBIC	

The International Bank Account Number (IBAN) and SWIFTBIC are likely printed on your account statements or your bank will be able to provide you with this information.

This information will be used only for the purposes of making any payment to you due under your Sportscover player accident insurance after which it will be destroyed.

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Sportscover Europe Limited (Claims) Short Privacy Notice
DATA PRIVACY NOTICE

How we use your data:

Sportscover Europe Ltd takes your privacy very seriously and will only use your personal information to administer your account and provide the products and services that you have requested.

This information may include basic contact details such as names, addresses, and policy number, but may also include more detailed personal information about individuals (for example, their age, health, details of assets, claims history) where this is relevant to the claim. We are underwriting, handling claims and providing services on the insurer's behalf and will pass information to our insurers and others as required.

Individuals have a number of rights in relation to their personal information, including rights of access and, in certain circumstances, erasure.

This notice represents a condensed explanation of how we use personal information.
For more information, please refer to our Data Privacy notice.

A copy of our full Data Privacy Notice can be obtained by contacting the Data Protection Officer by email at the address below:

Data Protection Officer
Sportscover Europe Limited
Second Floor
153 Fenchurch Street
London
EC3M 6BB

Tel: +44 (0)20 7444 1780
Email: claims@active-risk.com
Web: www.sportscovereurope.com

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