SPORTSCOVER EUROPE

Player Accident Claim Form

Registered address:
8 Eagle Court, London, EC1M 5QD

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

SPORTSCOVER EUROPE

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 ◯

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 ◯

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:			

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.

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	

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)*

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	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)*

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	

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		

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		

Witness statement

We require a statement from anyone who witnessed your accident. Please have that person complete this section.

55 Witness personal details

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
8 Eagle Court
London
EC1M 5QD

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

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.

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
8 Eagle Court
London
EC1M 5QD

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

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