



GAA Injury Scheme  
 Administered by Willis, Grand Mill Quay, Barrow St, Dublin 4.  
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## GAA INJURY CLAIM FORM

AS A MINIMUM THE FIRST TWO PAGES MUST BE SUBMITTED TO WILLIS WITHIN 60 DAYS OF INJURY. CLAIMS REPORTED OUTSIDE THE 60 DAYS WILL NOT BE PROCESSED.

### HOW TO COMPLETE THIS FORM

MEDICAL EXPENSES > SECTIONS A, E, F

LOSS OF WAGES (EMPLOYED) > SECTIONS A, C, D, E, F

LOSS OF WAGES (SELF EMPLOYED) > SECTIONS A, B, D, E, F

Claim No. \_\_\_\_\_

### Section A. TO BE COMPLETED IN ALL CASES. PLEASE USE BLOCK LETTERS

Claimant/Injured Person

Name of Club/County (or School/College etc.)

Full Address of Claimant

  
  


Full Address of Club

  
  


Date of Birth

Type of Team (e.g. Football, Hurling, Handball or Rounders)

Contact Number

Grade of Team (e.g. Senior, U18 etc.)

Claimant's Email Address

Occupation (if applicable)

Team

A  B  C

Employment Status (tick as appropriate)

Student  Employed  Self Employed  Unemployed

#### Medical Insurance Details

VHI? Yes  No  Other Insurance? Yes  No

Laya Healthcare? Yes  No  Aviva? Yes  No

Please specify full name of your Medical Insurance Cover Plan

The Injury Scheme only provides cover for non-recoverable costs up to the limit specified under the scheme. If you have medical insurance, a claim must be made with your Medical Provider. Therefore you must supply a statement of account or letter confirming you are not covered for your medical costs from your Medical Provider.

Failure to supply same will delay the assessment of your claim.

**Section A. TO BE COMPLETED IN ALL CASES. PLEASE USE BLOCK LETTERS**  
Continued

**Nature of Possible Claim (tick as appropriate)**

Loss of Wages

- Applicable to Adults/Youths who are in full time employment at date of injury ('employment' means – permanent gainful employment of not less than 16 hours per week).
- Benefit is payable for full weeks only up to a maximum of 52 weeks **excluding** the first week.
- The maximum benefit payable is as follows –  
Week 1 – €Nil  
Weeks 2 to 4 – Up to €200  
Weeks 5 to 52 – Up to €400
- The Injury Scheme only provides cover for non-recoverable costs of nett basic wage (excluding overtime, bonuses, unsociable working hours, allowances etc.). Social Welfare/Income Protection and/or other entitlements will be considered as recoverable income and will be deducted from the basic nett wage figure.

Dental Expenses

Non-recoverable dental expenses up to a limit of €4,500, **excluding** the first €100 of each and every claim

- Original receipts only will be accepted

Supplementary Hospital Benefit

Benefit payable – €400 per days stay in hospital. Benefit only payable if stay is a minimum of 10 consecutive days up to a maximum of 15 days.

Permanent Disability

Lifetime Disability Benefit – €300,000

Medical Expenses

- If you have medical insurance e.g. VHI, Quinn Healthcare, a claim must be made with your medical provider. Otherwise unrecoverable medical expenses are covered up to a maximum of €4,500 (This benefit includes cover for MRI Scans up to a limit of €300 per scan and Post Operative treatment up to a limit of €320. A maximum benefit of €40 per any one treatment applies).
- The first €100 of each and every claim is excluded.
- Original receipts only will be accepted

(i) Capital Benefits

\*Permanent Total Disablement – €100,000

\*Loss of sight – €100,000

\*Permanent Partial Loss of Sight – Up to €100,000

\*Loss of Limb(s) – €100,000

\*Complete and incurable paralysis – €100,000

\*All above benefits Less any Loss of Wages Benefit claimed.

(ii) Death Benefit

Adult (or Married Youth) – €50,000

Youth – €25,000

**The above is purely a summary of benefits payable for assistance when completing this claim form.**

**Hurling Injuries Only (tick as appropriate) Were you wearing a helmet with a faceguard that carries the CE Mark?**

Yes  No

**Underage Football Injuries Only (tick as appropriate) Were you wearing a mouthguard that carries the CE Mark?**

Yes  No

Date of Injury

Opposition

Nature of Injury

Brief Details of Circumstances

  

**Injury Occurred during (tick as appropriate)**

Official Match

Official Training Session

Challenge Match

Claimants Signature

Date

## Section B. LOSS OF WAGES CERTIFICATION – FOR COMPLETION BY SELF EMPLOYED CLAIMANT

Name of Company

Address

Business Description

Nature of Employment (e.g. farmer, sole trader, partnership)

Amount of average nett weekly income

€

Weekly nett wage paid to substitute worker(s) (if any)

€

Reason for loss of income

I declare that I am unfit for work following injury as a result of participating in Gaelic Football, Hurling, Handball or Rounders and unable to earn my average nett weekly income.

I attach

- (i) **Confirmation of my loss of nett weekly wages from my Accountant (include Chartered Accountants Registration No.)**
- (ii) **Details of my claim with the Department of Social and Family Affairs or the Social Security Agency.**
- (iii) **Details (if applicable) of any benefit received from my Income Protection policy.**

Signed

Date

## Section C. LOSS OF WAGES CERTIFICATION – FOR COMPLETION BY CLAIMANT'S EMPLOYER Continued overleaf

Employer's Name

Phone Number

Company Registration Number

Address

Employee's Name

Employee's RSI No

Employee's RSI Class

Date employment commenced

Date last worked

Date of notification of loss of wages

**Section C. LOSS OF WAGES CERTIFICATION –  
Continued FOR COMPLETION BY CLAIMANT’S EMPLOYER**

Reason for loss of wages

Date returned to work

**Amount of loss of Basic Nett weekly wages  
(excluding overtime, allowances etc.)**

€

**(Please attach 3 recent payslips or a letter from employer stating your nett weekly wage)**

Is the above employee contributing to a company VHI or equivalent scheme?

Yes  No

I hereby certify that the employee is at a loss of nett weekly wages and was in permanent employment of at least 16 hours on average per week prior to the loss and no sick pay scheme is in operation.

Personnel Officer’s/Manager’s Name (block capitals)

Personnel Officer’s/Manager’s Signature

Date

**Employer’s Stamp**

(if no stamp available  
please attach a letter  
on company headed  
paper confirming the  
above details)

**Section D. (i) SOCIAL WELFARE BENEFIT – FOR COMPLETION BY SOCIAL WELFARE OFFICE  
(A claim must be made with your local Social Welfare Office)  
(ii) STATUTORY SICK PAY CERTIFICATION (FOR RESIDENTS OF NORTHERN  
IRELAND ONLY) – FOR COMPLETION BY CLAIMANT’S EMPLOYER**

I certify that the above named has been in receipt of Illness Benefit for the period

/  /  to  /  /  at a rate of €  per week

I certify that the above named is not entitled to Illness Benefit for the period

/  /  to  /  /

as (please state reason)

  
  
  

Official’s Name (block capitals)

Official’s Signature

Date

**Official Stamp**

**Section E. MEDICAL CERTIFICATION – FOR COMPLETION IN ALL CASES BY THE DOCTOR/ DENTIST ONLY WHO ATTENDED THE CLAIMANT.**

**Cost of completion of the Medical Section of this claim form must be borne by the claimant**

Patient's Name

Patient's Date of Birth

Patient's Address

Please state specific diagnosis

Cause of disability and details of treatment administered/prescribed

Date of diagnosis

Date patient first consulted you for this disability

Date from which unfit for work

Date fit to return to work (if known)  
If unknown, please give estimate

Has the claimant ever had this or a similar disability/treatment before? If Yes, please give date and detail

Yes  No

  

Please Indicate if this injury is GAA related

Yes  No

**Doctor's/Dentist's Declaration**

I declare that to the best of my knowledge, the above information is accurate and correct and that the disability has been continuous as stated above.

Name (block capitals)

Signature

Telephone No

**Stamp**

(if no stamp available a business card or confirmation on the qualified practitioners headed paper must be submitted)

Date

**Section F. TO BE COMPLETED IN ALL CASES BY CLAIMANT, CLUB SECRETARY AND COUNTY SECRETARY**

**Claimant's Declaration**

I declare that to the best of my knowledge, the foregoing statements are true in every respect. I hereby authorise the doctor/dentist/hospital/employer/VHI/ Laya Healthcare/Aviva/Dept. of Social Welfare to supply any information requested. I understand that any deliberate misstatement will void the claim in its entirety.

I consent for the purposes of the Data Protection Acts, 1988 and 2003 to the information I give on this claim form and any other form issued to me in connection with this claim and to any other information that I give in relation to this claim being held and assessed by Willis and the GAA.

I give my authorisation that any information pertaining to this claim may be provided to any persons deemed relevant by Willis and/or GAA in assessment of this claim.

Signature

Date

**Club Secretary's Declaration**

I declare that the above named claimant was injured as a result of participating in an Official Match/Challenge Match as recorded in the attached Referees Report. Yes  No

I declare that the above named claimant was injured as a result of participating in an Official Training Session. Letter attached from Club Chairman/Secretary confirming same. Yes  No

I declare that the above named claimant was injured in accordance with Clause 1.4. Letter attached from Club Chairman/Secretary confirming the claimant's membership and stating the circumstances surrounding the accident/injury. Yes  No

**Claimant's Membership Number**

Name (block capitals)

Signature

Date

**Passed by County Secretary**

I declare that the above named claimant was injured as a result of participating in an Official Match/Challenge Match as recorded in the attached Referees Report. Yes  No

I declare that the above named claimant was injured as a result of participating in an Official Training Session. Letter attached from Club Chairman/Secretary confirming same. Yes  No

I declare that the above named claimant was injured in accordance with Clause 1.4. Letter attached from Club Chairman/Secretary confirming the claimant's membership and stating the circumstances surrounding the accident/injury. Yes  No

Name (block capitals)

Date

