Personal Accident Claim Form

***Please ensure that all receipts for your medical expenses are submitted to your Private Health Insurer first, as the policy does not extend to cover medical costs which are covered under your Private Medical Insurer. Please note policy limits may apply.**

Claimant Details **Claim Reference:**

Title	Full Name	Date of Birth	Occupation	Usual Country of Domicile

Contact Details
Claimant Address:
Postcode:
Daytime Telephone:
Email Address:
Wherever possible we will try and communicate with you by Email or telephone for a quicker service.

Please indicate your reason for claiming:-	Accident	☐	Illness	☐

Date and time of the accident or onset of illness:	dd / mm / yy HH:MM
Date you stopped performing your normaloccupation:	dd /mm / yy
Are you still incapacitated as a result of your accident or illness?	Y / N
If No please confirm the date you returned to work:	dd / mm / yy
Have you returned to work in the same capacity as before your accident or illness:	Y / N

If No please confirm the hours worked and the duties performed:
Continue on a separate sheet if necessary.

Are you medically signed off from work?
If Yes please attach a copy of the latest medical certificate to the claim form.

Event you were injured in:

Please provide full details of where and how the accident occurred.
Continue on a separate sheet if necessary.

Please describe injuries sustained in the accident or the nature of the illness:

If the accident was as a result of criminal assault or a road traffic accident, please confirm the details of the police station dealing with the case and the incident report number:

Please provide the full name and address of every doctor consulted for the present injury or illness also including the details of your usual GP.

Please Return All Documents to 17 Herbert Place, Dublin 2.

When did you first seek medical treatment for your accident or illness?		dd/mm /yy HH:MM
Were you admitted to hospital as a result of your accident or illness?		Y/N
If Yes please confirm the dates of admission and discharge:	dd/mm/yy	dd/mm/yy
What is your expected date of return towork?		dd/mm/yy
Have you previously claimed benefits under this insurance?		Y/N

If Yes, please provide full details:

Can you please advise if you are covered for Medical Expenses under a Private Health Insurance policy? Y/N

If Yes, can you please provide your insurers name and the name of your plan?

Official Report

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

Name

Position

Address for correspondence

Telephone

Name of club

Was the player registered at the time of the accident?

Registration number

Date of registration

Were you a witness to the accident described?

If yes, please provide details of the event.

If no, please provide the details of a witness to the event

Name
Address
Telephone

Please provide a copy of the club's team sheet or scoresheet where the accident details have been recorded.

Declaration of club official
I certify that the particulars shown on this form by the player are, to the best of my knowledge, true and correct.

Signature:

Date:

Data Protection

O'Driscoll O'Neil DAC complies with the requirements of the General Data Protection Regulation 2018 and the Irish Data Protection Act 2018. O'Driscoll O'Neil DAC is a Data Controller as defined in the Act. We collect your personal details in order to provide the highest standard of service to you. We take great care with the information provided; taking steps to keep it secure and to ensure it is only used for legitimate purposes. To fulfil these objectives we may share information with other affiliated professionals with your permission.

The data which you provide to us will be held on a computer database and paper files for the purpose of arranging transactions on your behalf. The data will be processed only in ways compatible with the purposes for which it was given and as outlined in our Data Privacy Notice and Data Protection policy.

Please contact us at dpo@odon.com if you have any concerns about your personal data. Should you require further information our Data Protection Privacy Statement is available for download at www.odon.com or contact us at dpo@odon.com or 016395800 and we will provide you with same.

For more information on how Sedgwick Claims Management Services Ltd use your personal information please see their full privacy notice at: https://www.sedgwick.com/assets/uploads/documents/EUPrivacy-Policy-v6.1.pdf .

If you have questions or concerns regarding the way in which your personal information has been used by Sedgwick Claims Management Services Ltd, please contact: dataprotection@cl-ie.com .

Declaration

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature: _____ Date: dd/mm/yy

Full Name: _____

Medical Certificate – to be completed by the patient's usual General Practitioner who must be a duly qualified and registered Medical Practitioner. Please note that any charge made for the completion of this medical certificate is the responsibility of the claimant and is not refundable under the insurance cover.

Full name of the patient:		Date of Birth:	dd/mm/yy
Are you the above named usual GP?	Y/N	If yes for how long?	

Please confirm the exact nature of the accident or illness sustained, together with prognosis and treatment given:

At the time of the accident or commencement of the illness was the patient suffering from any other illness or disability? Y/N

If Yes, please provide full details and whether the medical condition is affecting their recovery?

Is the disability due to Human Immunodeficiency Virus (HIV) and/or any HIV related sickness, any psychiatric, mental or nervous disorder, mental sickness, anxiety, stress or depression, self-inflicted injury, drug abuse, sexually transmitted disease, pregnancy or childbirth related conditions? Y/N

If Yes, please provide details:

When do you expect the patient to be able to return to work? dd/mm/yy

Will the patient be able to return to full duties on the above date? Y/N

If No, please confirm the extent of duties the patient will be able to perform and the number of hours the patient will be able to work per day:

Doctors Declaration

I confirm that the patient named above is/was under medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation **From** dd/mm/yy **To** dd/mm/yy

Doctors Name (please print) Date dd/mm/yy

Doctors Qualifications

Doctors Signature

Doctor's Official Stamp

Bank Details

- If your claim is agreed please provide your bank details.
- Please ensure that your bank details are written clearly to ensure any payment is processed efficiently.
- Please ensure all below fields are fully completed or your claim form will be returned.

Payment Method		Bank Details	
Payment into Bank Account		Bank Swift Code: For payments to any Country.	
		Bank IBAN : For payments to all European countries.	
		Account Number:	
		Name of Account Holder:	
		Country of Bank:	
		Bank Name and Address:	

Checklist:

Please return this checklist with your claim form and any supporting documentation to:
O'Driscoll O'Neil DAC
17 Herbert Place
Dublin 2

Medical Expense Claim:

Documents to enclose with your claim form:	**Tick**
Fully completed claim form and medical certificate. This will be returned to you if any field is left unanswered. For dental expenses please ensure your dentist completes the medical certificate.	
Original receipts and the supporting invoices for medical expenses incurred. All expenses must be paid upfront and the receipts submitted for consideration. Photocopies will not be accepted unless originals were obtained by a private health insurer. (If you hold private health insurance you must submit a claim through the private health insurer first as this policy only covers irrecoverable expenses).	
Physiotherapy expenses will only be considered where a referral letter from a medical practitioner has been obtained.	