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BRITISH GYMNASTICS

PERSONAL ACCIDENT CLAIM FORM

ONCE COMPLETED THIS FORM SHOULD BE RETURNED TO W DENIS INSURANCE BROKERS PLC

This form should be completed by Claimant if over 18
If under 18 the form must be completed by parent / guardian

SECTIONS 1-6 MUST BE FULLY COMPLETED IN ALL CASES
REMAINING SECTIONS REQUIRE COMPLETION AS INDICATED BELOW

Please confirm under which section of the Personal Accident Policy you wish to claim:

Death/Funeral Expenses	YES / NO
Capital Benefits (Permanent Disablement)	YES / NO
Dental treatment following injury	YES / NO
Medical Expenses e.g. Physiotherapy, Radiotherapy, Manipulative Massage, Soft Tissue Treatment Complete Sections 7 & 8 and Provide Completed medical Certificate	YES / NO
Hospital benefit Complete Section 9, Doctor to Complete Hospitalisation Certificate or Provide Hospital Discharge Paperwork	YES / NO
Travel/Accommodation expenses of relatives Complete Section 10, Doctor to Complete Hospitalisation Certificate or Provide Hospital Discharge Paperwork	YES / NO
Loss of Earnings as a Coach Complete Section 11 and Provide Evidence of Earnings & GP Sick Note(s)	YES / NO

IN ORDER TO AVOID ANY DELAY IN YOUR CLAIM BEING PROCESSED PLEASE ENSURE:

	TICK
➢ THE CLAIM FORM HAS BEEN COMPLETED, FULL PAYEE DETAILS PROVIDED AND FORM IS SIGNED	( )
➢ THE MEDICAL CERTIFICATE HAS BEEN COMPLETED BY TREATING PRACTITIONER IF APPLICABLE	( )
➢ A COPY OF YOUR BG MEMBERSHIP CARD IS ATTACHED	( )
➢ ALL RECEIPTS/INVOICES FOR TREATMENT (BODY PART TREATED MUST BE IDENTIFIED) ARE ATTACHED	( )

PLEASE NOTE THAT INSURERS WILL NOT BE ABLE TO CONSIDER ANY MEDICAL EXPENSES INVOICE(S) WHERE THE AREA OF THE BODY TREATED IS NOT IDENTIFIED.
ANY SUCH INVOICE(S) WILL BE RETURNED TO YOU UNPAID FOR AMENDMENT BY THE TREATING PRACTITIONER

1) Injured Person

Name: _____ Date of Birth: _____

Address: _____

_____

_____ Postcode: _____

Telephone No: _____

Email Address for contact (please tick if this is preferred method of contact) [ ]

_____

BG Membership No: _____ Level of Membership: _____

** A COPY OF YOUR MEMBERSHIP CARD MUST BE PROVIDED **

Name and Address of Club: _____

_____

_____

Currently Employed: YES / NO Usual Occupation: _____

2) Date and Time of Accident: _____

3) State briefly how and where the injury occurred, providing full details of the agility / activity being attempted: _____

_____

_____

_____

_____

4) Details of Injury Sustained: _____

_____

5) Name & Address of Witnesses: _____

_____

_____

_____

6) Please provide your Doctors / Dentist* name and full address (*delete as appropriate)

_____

_____

_____

PLEASE COMPLETE THE FOLLOWING SECTIONS ONLY AS INDICATED ON THE FIRST PAGE OF THE FORM.

7) Type of Medical Expenses claimed for: _____

Name & address of the specialist providing treatment
(please ensure the specialist completes the medical certificate)

_____

_____

8) Who advised you to seek this medical treatment? Name and relationship (e.g. GP, Coach)

_____

_____

9) Name of Doctor / Consultant and Address (if claiming for hospital benefit)

* THE DOCTOR MUST COMPLETE THE CERTIFICATION INFORMATION BELOW *

_____

_____

Hospitalisation Certificate

TO THE CLAIMANT - PLEASE ASK THE TREATING DOCTOR TO COMPLETE THIS FORM.

TO THE DOCTOR – PLEASE COMPLETE THE INFORMATION BELOW:

I, the undersigned, hereby confirm that

Patients Name:_____

as a sole result of the accident which occurred on

Date of Accident: _____

was an inpatient at (name of hospital)

_____

Date / time the patient was:

Admitted:_____

Discharged:_____

Signed _____ Date _____

Qualification(s) _____

NOTE FOR DOCTORS – ANY FEE FOR THIS CERTIFICATE IS TO BE PAID BY THE PATIENT.

10) Details of any travel or accommodation expenses incurred:
COVER APPLIES WHEN THE INJURED PARTY IS ADMITTED TO A HOSPITAL MORE THAN 10 MILES FROM THEIR USUAL RESIDENCE FOR MORE THAN 5 CONSECUTIVE NIGHTS AS A RESULT OF A GYMNASTICS INJURY

What is the relationship between the person claiming under section 10 and the injured person?

11) Coaches Loss of Earnings
PLEASE NOTE THAT INSURERS DO NOT PAY FOR THE FIRST 4 WEEKS LOST WAGES

What is your average weekly income from coaching gymnastics / trampolining?

PLEASE ATTACH:

1. EVIDENCE OF YOUR EARNINGS FOR THE 13 WEEKS PRIOR TO THE INCIDENT AND WAGE SLIPS ISSUED DURING YOUR ABSENCE IN RESPECT OF COACHING GYMNASTICS / TRAMPOLINING
2. SICK NOTES FROM YOUR GP CONFIRMING THAT YOU ARE UNABLE TO COACH

If your claim is successful, please confirm who any cheques should be payable to (FULL NAME):

Please note that if the payee information is provided with initials only this will result in a delay in the payment process.

Alternatively, if you would prefer any payment via BACs please provide your bank information on the attached sheet. These details will be retained only until your claim is concluded and will then be destroyed in accordance with Data Protection requirements.

DATA PROTECTION:
All information you provide on this form is treated by us as confidential and except to the extent required by law, we shall only use such information for the purpose of processing your claim. Information you provide may be forwarded to your Insurer for these purposes.

Declaration by all applicants

I confirm that to the best of my knowledge the above information is correct.

Signature _____ Date _____

Print Name _____

CLAIMANT / PARENT / GUARDIAN (Delete as appropriate)

MEDICAL CERTIFICATE

(TO BE COMPLETED BY THE TREATING PRACTITIONER)

This is to certify that (name of patient) _____

Is suffering from (nature of injury) _____

_____

Date of Injury: _____

Treatment Commenced / To Commence: _____

Is there any history of a similar previous injury? YES / NO

If YES please give details:

_____

_____

How frequently do you anticipate providing treatment? _____

_____

How long is treatment likely to continue for? _____

PLEASE NOTE THAT IF TREATMENT CONTINUES FOR MORE THAN 12 WEEKS A FURTHER MEDICAL CERTIFICATE REGARDING THE UPDATED PROGNOSIS AND RECOVERY PERIOD WILL BE REQUESTED

Are there any factors which might have contributed to the injury which might delay recovery?

YES / NO

If YES please give details:

_____

_____

Your Address:

_____

_____

_____

Qualification(s):

_____

Signature: _____

Please print name: _____

Date: _____

NOTE FOR DOCTORS – ANY FEE FOR THIS CERTIFICATE IS TO BE PAID BY THE PATIENT.

BANK INFORMATION FOR BACS PAYMENTS

Full name(s) of the account holder(s) _____

Sort code _____

Account number _____

Bank Name _____

Bank Address _____

Please note that insurers are unable to issue a payment if they are not provided with the full first and surname(s) of the account holder(s).
If payee information is provided with initials only this will result in a delay in the payment process.