



W Denis Insurance Brokers PLC

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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

PLEASE NOTE THAT TO ENABLE THE INSURER TO CONSIDER ANY CLAIM FOR THE COST OF MEDICAL EXPENSES FOLLOWING AN ACCIDENT AT GYMNASTICS, EVERY TREATMENT INVOICE MUST CONFIRM THE AREA OF THE BODY TREATED.

ANY INVOICE(S) WHERE THE BODY PART IS NOT CONFIRMED WILL BE RETURNED TO YOU, UNPAID, FOR AMENDMENT BY THE TREATING PRACTITIONER

THE CONFIRMATION OF THE AREA OF TREATMENT CAN BE ONE OF THE FOLLOWING:

1. ELECTRONIC INVOICE(S) CONFIRMING BODY PART TREATED
2. HANDWRITTEN ENDORSEMENT ON EACH INVOICE, SIGNED AND DATED BY THE TREATING PRACTITIONER
3. A LETTER, ON PRACTICE HEADED PAPER, CONFIRMING THE DETAILS OF THE RELEVANT INVOICE(S) AND TREATMENT PROVIDED

PLEASE NOTE THAT CONFIRMATION OF THE BODY PART ON THE MEDICAL CERTIFICATE IS NOT SUFFICIENT FOR INSURERS PURPOSES.

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:**

- |   |             |
|---|-------------|
| ➤ THE CLAIM FORM HAS BEEN COMPLETED, FULL PAYEE DETAILS PROVIDED AND FORM IS SIGNED       | TICK<br>[ ] |
| ➤ 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 | [ ]         |

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 AVAILABLE TO SILVER AND GOLD MEMBERS 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

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

- 11) **Loss of Earnings as a Coach**  
PLEASE NOTE THAT INSURERS DO NOT PAY FOR THE FIRST 4 WEEKS LOST WAGES  
COVER APPLIES ONLY IF THE INJURY WAS SUSTAINED WHILST COACHING

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

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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):

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*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/ TREATING PRACTITIONER – ANY FEE FOR THIS CERTIFICATE IS TO BE PAID BY THE PATIENT

BANK INFORMATION FOR BACS PAYMENTS

*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.*

Full name(s) of the account holder(s) \_\_\_\_\_  
Sort code \_\_\_\_\_  
Account number \_\_\_\_\_  
Bank Name \_\_\_\_\_  
Bank Address \_\_\_\_\_