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IRISH RUGBY FOOTBALL UNION
GROUP PERSONAL ACCIDENT SCHEME
- ACCIDENT CLAIM FORM -

N.B. ***All questions must be answered fully.***

(A) PERSONAL ACCIDENT SECTION
(If unable to apply personally, this form may be filled up on behalf of the claimant)

Name of Claimant in full .....

Address .....

..... Phone no: .....

Present Business of Occupation .....

Business Address .....

.....Present age: .....

Name of Club and Address .....

1.	State when and where the accident took place	It occurred at ..... a.m./p.m. on the .....day of 200
2.	State how it happened, and what you were doing at the time. ***(It is necessary that the fullest particulars be given)***	
3.	State as precisely as you can, what injuries you have sustained	
4.	Are there any other insurances that can operate (i.e. VHI, National Health) If so, please give details including Insurer, Policy number. **PS:** ***Claimant's attention is drawn to Proviso 3 which states that Medical Expenses are only payable under this insurance when all other sources have been exhausted)***	

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(A) PERSONAL ACCIDENT SECTION ..... Continued

5.	Have you been totally unable to attend to any portion of your business. If so, give the dates. In bed ..... Confined to the house (a) are you totally unable to attend to any portion of your business (b) If so, probable period of incapacity	 From the ..... to the ..... From the ..... to the .....
6.	On what dates since the accident were you able to attend: (a) to a portion of your usual business or occupation (b) to the whole of your usual business or occupation	
7.	Have you previously suffered from the injury sustained or any associated trouble. If so, please give details:	

DECLARATION

I do hereby declare that the foregoing particulars are true in every respect.

SIGNATURE OF CLAIMANT: .....

DATE: .....

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N.B. ***All questions must be answered fully.***

- MEDICAL CERTIFICATE -

(The claimant must obtain, at his own expense, the following Certificate from a duly qualified and registered Medical Practitioner)

NAME OF CLAIMANT: .....

1.	When did you first attend upon the claimant in consequence of the injuries sustained?	
2.	Are you still in attendance?	
3.	Are you the usual Medical Attendant of the claimant, and, if so, how long have you known him?	
4.	What was the cause of the accident, so far as is known to you?	
5.	What injuries were sustained - (a) Regions injured (If hand or an arm, a foot or a leg, state whether it is the right or left) (b) Nature and extent of the injuries (c) Are the symptoms from which he suffers due to - (i) the accident alone or (ii) are they traceable to any other cause?	
6.	Is the claimant now, or was he at the time of the accident, subject to or suffering from any illness or disease, irrespective of his injuries? If so, state the nature of same, and to what extent the recovery of claimant may be affected thereby.	
7.	If you are the usual Medical Attendant of the claimant, are you aware of anything in his previous medical history which might have contributed, directly or indirectly, to the occurrence of the accident, or which may be likely to retard in any way his recovery from it?	
8.	Is claimant confined to his bed, bedroom, or house by your directions? Has he at any time been so confined since the date of the accident? If so, give the dates.	

- MEDICAL CERTIFICATE -
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(The claimant must obtain, at his own expense, the following Certificate from a duly qualified and registered Medical Practitioner)

NAME OF CLAIMANT: .....

9.	If still so confined, please state your opinion as to the probable duration of such confinement, and probable date of his being able to resume some portion of his usual business or occupation.	
10.	Are you prepared to certify that the claimant is/has been **totally** disabled from attending to any portion of his/her occupation as .....? If so, from what date did the claimant's temporary total disablement commence?	
11.	If claimant has been able to attend to a **portion only** of his usual business or occupation, please state from what date partial disability commenced.	
12.	If claimant has ceased to be (a) totally disabled (b) partially disabled please state from what date or dates	
13.	General Remarks	

DECLARATION

I certify that the foregoing statements are correct.

SIGNATURE OF CLAIMANT: .....

ADDRESS: .....

QUALIFICATION: .....

DATE: .....